REQUESTS FOR PROPOSALS

for

SCHOOL-BASED AND SCHOOL-LINKED CHILD AND ADOLESCENT HEALTH CENTERS & PLANNING GRANTS

***Issued Collaboratively By*:**

Michigan Department of Education

&

Michigan Department of Community Health

Proposals Due by February 14, 2005

MICHIGAN DEPARTMENT OF EDUCATION AND
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
December 2004

ANNOUNCEMENT FOR REQUESTS FOR PROPOSALS FOR SCHOOL-BASED OR SCHOOL-LINKED CHILD AND ADOLESCENT HEALTH CENTER FUNDING

This packet includes:

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- Part I: General Information
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- Attachments
- Application Form (IM-02-77) and Assurances and Certifications

NATURE OF ACTION REQUESTED: _____X_____ VOLUNTARY

The Michigan Departments of Education and Community Health are pleased to announce the availability of funding for School-Based and School-Linked Child and Adolescent Health Centers (SBSL-CAHC), including planning grants to start new centers. Approximately **$8,800,000** is available for funding both existing School-Based and School-Linked Child & Adolescent Health Centers and for planning grants to start new clinical centers. Criteria for the Child & Adolescent Health Center Grants were approved by the Children's Cabinet at its November 17, 2004 meeting and follows criteria approved by the State Board of Education on June 13, 2002. The grants will be awarded through a competitive process.

The grant application for Child & Adolescent Health Centers including all required forms is available on the Michigan Department of Education website. Completed applications must arrive on or before February 14, 2005. **An ORIGINAL and FOUR (4) copies (for a total of five) of the completed application must be submitted at that time.**

The application and a *"Frequently Asked Questions CAHC Message Board"* will be available for public use throughout the application-writing period at www.michigan.gov/mde. To download the application, related forms, and frequently asked questions, click on K-12 Curriculum, under the Health Education bar click on Coordinated School Health and Safety Programs. The information is located under the "***What's New***" section. Any questions regarding the application **must** be posed in writing to Carrie Tarry and Elizabeth Coke Haller. Responses will be delivered in writing through its posting on the web and will be available for public access within

two business days of receipt of the original question. This "message board" will replace a formal pre-bid meeting. It is up to each applicant to regularly check the *FAQ CAHC Message Board*. Questions regarding the Child and Adolescent Health Center grant application process may be directed to Carrie Tarry, Adolescent Health Services Coordinator at the Michigan Department of Community Health at tarryc@michigan.gov or (517) 335-8906 or Elizabeth Coke Haller, Coordinated School Health & Safety Programs Manager at Michigan Department of Education at hallere@michigan.gov or (517) 335-0565.

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MICHIGAN DEPARTMENTS OF EDUCATION AND COMMUNITY HEALTH
December 2004

APPLICATIONS FOR CHILD & ADOLESCENT HEALTH CENTERS

PART I: GENERAL INFORMATION

INTRODUCTION:

The Michigan Departments of Education and Community Health are pleased to announce the availability of funds for Child & Adolescent Health Centers (CAHC). Section 31a, Subsection 6 of the State School Aid Act of 2002-2003 (*Attachment A*) provides $3,740,000 for Teen Health Centers. A federal match opportunity for Teen Health Center funding provides a total appropriation of **$8,800,000** available to the field for FY05-06. *Funding for Planning Grants and Health Centers not currently receiving FY04-05 funds for the CAHC program that are selected through this competitive process will begin contracts on April 1, 2005*. CAHCs *currently receiving State funding who are selected through this competitive process will begin contracts on October 1, 2005*.

School-based and school-linked health center services have been provided in Michigan since the 1980's. State funding for such services began in 1987 through the Michigan Department of Public Health (now the Michigan Department of Community Health) and were focused exclusively on the adolescent population. Leveraged federal funding has allowed for the expansion of clinical services to the elementary age population (youth 5 and over). The CAHC program is jointly managed by the two State Departments.

School-based health centers are primary care centers that are LOCATED ON SCHOOL PROPERTY. School-linked health centers are primary care centers that have strong ties to surrounding schools or school districts but are NOT LOCATED ON SCHOOL PROPERTY. Centers operating on school property must follow School Code regulations.

Many children and adolescents in Michigan communities confront serious health concerns: unintentional injuries; child abuse and other interpersonal violence; alcohol, tobacco and other drug use; overweight and obesity; early pregnancy and childbearing; family conflict; depression and teen suicide. These problems have a direct, negative impact on school attendance, academic achievement and school completion. Many children and adolescents in Michigan lack adequate access to the health services needed to prevent and intervene in these health problems. A major emphasis of this program is to ensure that eligible children and adolescents within or linked to targeted schools are insured and have access to preventive services such as Early, Periodic, Screening, Diagnosis and Treatment (EPSDT). Increasingly, families cannot afford time away from school and work to seek needed health services. Many live in areas with limited healthcare providers, and lack health insurance, money, transportation and knowledge of how to use local health care systems.

Over one-third of Michigan's children continue to live in families only marginally above the poverty level. In 2003, roughly one in five young children in Michigan lived in poverty. The rates of well-child exams among Medicaid-enrolled children in 2003 were below the national

average. Michigan's annual average hospitalization rate (49 per 10,000) for asthma among young children in the three-year period 2000-02 is almost double the Healthy People 2010 target of 25 per 10,000. The rates of children in families investigated for neglect and abuse, confirmed victims and children in out-of-home care all increased between fiscal years 1995 and 2003. The number of children receiving free/reduced priced school lunches has also increased by 13% in the past ten years (Kids Count, 2004).

The period of adolescent growth and development is filled with risks and opportunities. These years mark the formation of health behavior patterns that have lifelong ramifications. Most young people, ages 10-21, growing up in the United States have the potential of maturing into responsible, healthy adults. However, certain groups of young people are limited because of their health status, the economic condition of their families/communities and their involvement in many high-risk behaviors, which include: school drop-out; use of alcohol, tobacco or other drugs; unsafe driving; early and/or unprotected sexual activity; fathering a child or becoming pregnant; poor nutrition; lack of exercise; and involvement in violent behavior. Adolescence is a time of change physically, emotionally and cognitively. While risk-taking behaviors are normal in the movement through this life cycle, adult and health-related intervention is often necessary to assure that these youth emerge safe and healthy. The adolescent population is currently the least likely age group to receive needed and appropriate health care services. Adolescent-specific school-based and school-linked health center models are designed to address this unmet need and provide services unique to the adolescent population in a "teen friendly" environment.

The Departments embrace the notion that "healthy kids learn better". Moving primary care services into or close to schools with significant numbers of uninsured and underinsured children and families that have problems accessing adequate health services, gives children and adolescents access to care in an environment that is tailored to their unique needs and conveniently located. Through the establishment of SBSL-CAHC services, interventions can be provided to the five to 21-year-old population with the aim of achieving the best possible physical, intellectual, and emotional health status. Funding of these programs, and ensuring on-going support for program growth that meets the needs of the community and the target population, requires collaboration with the state, local community organizations, parents and schools.

- Services offered by clinical school-based and school-linked health centers include at a minimum: 1) primary medical care including preventive services, 2) chronic disease management, 3) Medicaid outreach and enrollment, 4) access to Medicaid preventive services, 5) early intervention and other support services including psychosocial services, 6) health education; and 7) referral services.

- Services offered by non-clinical health centers can include limited clinical care that meets the unique needs of the adolescent population, case finding, health education, referral for primary and/or other needed health or psychosocial services, and Medicaid outreach and enrollment.

For a list of key terms and definitions for this competitive process, please refer to Attachment B.

MDCH and MDE embrace these two models as effective means for increasing access to basic health care for children and teens in under-served communities. There is a growing body of evidence that access to primary health care in schools can improve health status and learning readiness. **With this RFP, the Departments are seeking applications for existing school-based and school-linked health centers operating throughout Michigan and to support community efforts to initiate a planning process to determine the feasibility of starting a new clinical school-based or school-linked health center.**

GRANT PURPOSE

A major role of the school-based and school-linked health center models is to provide a safe and caring place for children and adolescents to learn positive health behaviors, prevent diseases, and receive needed medical care and support, thereby resulting in healthy youth who are ready and able to learn and become educated, productive adults. SBSL-CAHCs assist eligible children and youth with enrollment in Medicaid and provide access to Medicaid preventive services. SBSL-CAHCs are required to collaborate with Medicaid Health Plans as necessary to ensure that children and youth are receiving needed health services. It is crucial to have community acceptance and support for these child and adolescent health service models.

This request seeks competitive proposals for planning the delivery of health services to the five to 21-year-old population in geographic areas where it can be documented that health care services accessible and acceptable to children and youth require enhancement or do not currently exist. The services should aim at achieving the best possible physical, intellectual, and emotional status for the target population. The infants and small children of the adolescent population may also be served, where appropriate.

These grant application instructions are provided to interested and eligible parties to enable them to prepare and submit competitive proposals for the following:

1. **Planning Grants** – designed to provide support to communities interested in convening a planning process to determine the feasibility and community support for implementing a new clinical CAHC. During the planning process, communities will provide a limited number of Medicaid outreach activities to eligible children and youth in their service area.

2. **Clinical Child & Adolescent Health Center** – designed to provide primary care (including well care and diagnosis and treatment for both acute and chronic illness), psychosocial and health promotion/disease prevention services, Medicaid outreach activities and access to Medicaid preventive services in a "consumer" friendly manner and atmosphere to eligible children and youth.

3. **Non-Clinical Adolescent Health Centers** – designed to provide health care services that meet the unique needs of the adolescent population, health education, peer counseling, screening/case finding, referral for primary and/or specialty care, health-related community awareness activities, and Medicaid outreach activities to eligible youth. ***Non-clinical services must focus on the adolescent population only.***

If a community has undergone a planning process and has a clinic site developed with capacity to be operational including the ability to meet the State's minimum service requirements within 90 days of the start of the contract, follow the instructions outlined in Part V of this guidance for existing centers.

ELIGIBLE APPLICANTS

Eligible applicants include public and non-profit entities (e.g., local health departments, schools, community health centers, non-profit hospitals and other health care or social service organizations qualified to provide school-based or school-linked health care services). Documentation of incorporation as a non-profit agency or other legal status or evidence of application must be included with this application. Applicants must demonstrate collaboration between the local school district and health care providers in the proposal.

To be eligible for funding, all applicants must provide written assurance that abortion services, counseling and referrals for abortion services will not be provided as part of the services offered. For programs providing services on school property, written assurance will be required that family planning drugs and/or devices will not be prescribed, dispensed or otherwise distributed on school property as mandated in Michigan School Code. **These assurances must be included in the application cover letter.**

TARGET POPULATIONS TO BE SERVED

This request seeks proposals for the delivery of health services or for planning the delivery of health services to the 5-21 year old population in geographic areas where it can be documented that health care services accessible and acceptable to children and youth require enhancement or do not currently exist. The infants and small children of the adolescent target population may also be served where appropriate.

FUNDING LIMIT AND DURATION OF FUNDING

This grant will provide base funding for clinical and non-clinical CAHCs and planning grants. Funding recommendations for School Based Health Centers (SBHCs) suggest for program sustainability, a formula exist with equal partnership between state, school/local and community. The formula Michigan is working to maintain is derived from this national model of 1/3 state, 1/3 school/local and 1/3 community support. The intent of this grant is to provide funding for the state contribution of the recommended formula.

Base grants (clinical, non-clinical and planning) will vary due to unique differences in program operations, e.g., cost-based reimbursements and types of services provided.

- **Planning Grants** – 10 to 15 planning grants will be available[1].
  - ✓ Planning Grants will receive up to **$75,000** to conduct local planning to determine the feasibility, community commitment and documented need for implementing a new clinical school based/linked health center. If, at the end of the planning process, the community invited to continue forward with implementing a clinical

center, the grantees will receive base funding of either $175,000 or $225,000 annually (see above details for funding differences).

- **Clinical Child & Adolescent Health Centers** – 35 to 40 awards will be available[1].
  - ✓ School-Based Health Centers, which are located on school property, will receive base funding of **$175,000** per year.
  - ✓ Community-Based or School-Linked centers will receive base funding of **$225,000** per year.
  - ✓ Federally Qualified Health Centers (FQHC) that are Community-Based or School-Based will be eligible for the **$175,000** base funding allocation due to their unique ability to secure full cost-based reimbursement for services.

- **Non-Clinical Adolescent Health Centers** – 10 to 15 awards will be available[1].
  - ✓ Non-Clinical centers will receive base funding of **$85,000** per year.

START DATE OF FUNDING

Program funding will begin on separate dates depending on the type of grant awarded and/or current state funding status.

- For CAHCs that **currently receive** State funding and are awarded funding through this 2005 competitive process, the grant cycle will begin October 1, 2005 and end September 30, 2008.
- For CAHCs that **do not currently receive** State funding and are awarded through the 2005 competitive process, the grant cycle will begin April 1, 2005 with each grantee receiving a six-month allocation from April 1 – September 30, 2005. *Grantees are expected to be fully operational and meeting minimum State standards within 90 days of the start of the grant cycle.* Full grant allocations will begin October 1, 2005 and end September 30, 2008.
- **Planning grantees** will begin the planning process on April 1, 2005 and end September 30, 2005. For communities that are invited to move forward with initiating a new clinical CAHC, the grant cycle will begin October 1, 2005 and end September 30, 2008. Implementation of full services will vary depending on community readiness with the expectation that all planning grant centers are fully operational by October 1, 2006. Funding is available to support up to 10 planning communities invited to move forward with implementation.

Annual non-competitive applications will be due for all funded grantees in future years through September 30, 2008. Awards are contingent upon the availability of funds as well as the performance of the grantee in previous years. MDCH and MDE reserve the right to terminate any contract due to failure to meet established minimum program and reporting requirements and/or failure to meet annual negotiated performance numbers.

Neither MDE nor MDCH are liable for any costs incurred by applicants prior to the execution of a contract. **A local match of 30 percent of the amount requested is required.** Any match

[1] Numbers of awards are subject to change based on number of applications received.

provided by a collaborative partner must be documented in writing by that organization and included as part of this proposal. **If one organization is applying for more than one grant in different geographic locations or more than one model of funding, separate applications and budgets must be submitted.**

REJECTION OF PROPOSALS
MDE and MDCH reserve the right to reject any and all proposals received as a result of this announcement and will do so if the proposal does not adhere to funding specifications, or preparation instructions.

CLOSING DATE AND DELIVERY ADDRESS
Proposals are due on or before 5:00 p.m., Friday, February 14, 2005. If a proposal arrives after this due date or is submitted by fax or e-mail, it will not be considered or reviewed. Proposals submitted, but not in accordance with the proposal preparation instructions (below), will not be accepted and will be returned to the applicant *without review.*

The ORIGINAL proposal, bearing ORIGINAL signatures, and FOUR (4) COPIES (for a total of five) of the completed proposal must be documented by delivery agent for delivery on or before **Friday, February 14, 2005.** Proposals should be mailed via U.S. mail, U.P.S. or Federal Express or other similar courier in sufficient time as to arrive on or before the due date.

Proposals should be mailed to the attention of:

Michigan Department of Community Health
Adolescent Health Services Coordinator
ATTN: Carrie Tarry
P.O. Box 30195
Lansing, MI 48909

U.S. POSTAL SERVICE OVERNIGHT/EXPRESS MAIL

Michigan Department of Community Health
Adolescent Health Services Coordinator
ATTN: Carrie Tarry
3423 North MLK Jr. Blvd.
Lansing, MI 48909

You will receive a faxed confirmation of receipt of your proposal by the Michigan Department of Community Health within three business days of arrival at MDCH. **Complete Attachment D: Application Fax-Back Form and Checklist and include it as the cover page of your proposal**. If you do not receive this confirmation notice by fax within three days of submission of your proposal, please immediately call Carrie Tarry, Adolescent Health Services Coordinator at MDCH at (517) 335-8906.

Acceptable packaging and mailing procedures are:

- The postmark or other mailing validation must be documented by delivery agent for delivery **on or before February 14, 2005**. The original proposal and all required copies should be enclosed in a sealed envelope within the mailing packet. A completed checklist must be attached on the top of the inside envelope for appropriate check-in by the unit secretary. If the applicant used a delivery service, the dated receipt for delivery service must be available to validate the **February 14, 2005,** postmark requirement.

- When the proposal is received, the Application Fax-Back Form: Confirmation of Receipt on the front of the application package will be signed by the appropriate personnel and then faxed to the applicant to verify receipt of proposal and participation in the grant process. **The applicant is responsible for contacting Carrie Tarry at (517) 335-8906 or tarryc@michigan.gov by February 15, 2005 if the applicant does not receive a faxed copy of the signed form.**

- In case of late delivery of the proposal, verification of appropriate delivery efforts will be required to participate in this grant process.

The Departments will appoint an objective review committee to review and prioritize proposals for funding. Notification of award or rejection is expected by March 15, 2005.

PROPOSAL PREPARATION, PAGE LIMIT AND FONT SIZE

Proposals should be prepared simply and economically, providing a concise description of the requirements of the proposal with a narrative no longer than 30 pages in length for existing clinical and non-clinical CAHCs and no longer than 10 pages in length for planning grants. Proposals should be typed with a font no smaller than Times 12 point font, double-spaced, single-sided, and using standard one-inch margins. Applicants must number all pages sequentially.

Proposals should not be stapled together but rather sent in unbound. Individual binder clips should be used to bind each copy of the proposal(s). Special bindings and binders should not be used. Required forms and support documents (title page, table of contents, certifications and assurances, list of advisory council members, copies of policies and procedures, interagency agreements, budget forms, budget narrative, work plan, and letters of commitment/support and need) are not counted in the narrative page limit. Supplementary materials will not be reviewed and will be returned.

ACKNOWLEDGEMENT

All publications, including: reports, films, brochures, and any project materials developed with funding from this program, must contain the following statement: "**These materials were developed with state funds allocated by the Michigan Department of Education and Michigan Department of Community Health."**

NON-DISCRIMINATION AND OTHER COMPLIANCE WITH LAW

Proposals must include a statement of assurance of compliance with all federal and state laws and regulations prohibiting discrimination and with all requirements and regulations of the Michigan Department of Education and Michigan Department of Community Health.

AMERICANS WITH DISABILITIES ACT

MDE and MDCH are committed to providing equal access to all persons in admission to, or operation of its programs or services. Individuals with disabilities needing accommodations for effective participation in this program are invited to contact either of the two State Departments for assistance.

AVAILABILITY OF APPLICATION

The application packet is available from the Michigan Department of Education, at (517) 241-4284 and the Michigan Department of Community Health, at (517) 335-8906 and can be downloaded from: www.michigan.gov/mde, click on K-12 Curriculum, then under the Health Education bar click on Coordinated School Health and Safety Programs. The RFP is located under the "What's New" section.

WHERE TO OBTAIN ASSISTANCE

MDE and MDCH issues the instructions contained in these materials, and are the sole points of contact in the State for this program. Questions regarding proposals should be directed to either the Adolescent Health Unit at MDCH at (517) 335-8906 or the Coordinated School Health and Safety Program at MDE at (517) 335-0565.

A *"Frequently Asked Questions CAHC Message Board"* will be available for public use throughout the application-writing period. Any questions regarding the application **must** be posed in writing to Carrie Tarry and Elizabeth Coke Haller. Responses will be delivered in writing through its posting on the web and will be available for public access within two business days of receipt of the question. This "message board" will replace a formal pre-bid meeting. It is up to each applicant to regularly check the *FAQ CAHC Message Board* on the MDE website.

The FAQ *CAHC Message Board* can be downloaded from: www.michigan.gov/mde. To download information click on K-12 Curriculum, then under the Health Education bar click on Coordinated School Health and Safety Programs. The information is located under the "What's New" section. To submit questions to the message board, please send the written question via email or fax to both tarryc@michigan.gov and hallere@michigan.gov. Faxes should be sent to both (517) 335-8294 to the attention of Carrie Tarry and (517) 373-1233 to the attention of Elizabeth Haller.

PART II: ADDITIONAL INFORMATION

FUNDING PROCESS

The Departments will make the CAHC and planning grants available through a competitive process for fiscal year 2005-2006. Only those successful applicants receiving funding in the 2005-2006 funding cycle that have satisfactory progress in achieving performance measures as

evidenced by required progress and financial reporting will be invited to apply for continuation funding to operate a CAHC through the 2006-07 and 2007-08 funding cycles.

PAYMENT SCHEDULE
Michigan Primary Care Association (MPCA) will issue contracts to all grantees on behalf of the two Departments. Grantees will receive monthly payments from MPCA. Expenditures must be reported quarterly and year-end in accordance with the terms and conditions of this agreement and outlined in the CAHC contract issued by MPCA. Expenditures must be based on monthly reports, records, and other requested documentation maintained by the grantee.

FINANCIAL REPORTING
Quarterly and year-end expenditure report will be required of all grant recipients. The final expenditure report is due within 60 days of the end of the project year (by November 30, 2005). *All financial reporting requirements are detailed in Attachment E.*

PERFORMANCE REPORTING AND MONITORING RESPONSIBILITIES
After grants are awarded, the grantee will carry out the proposed programming under the general direction of MDE and MDCH. Program oversight, including technical assistance and consultation will be provided by MDCH. For existing centers, the services and activities described in the Minimum Program Requirements, *Attachment C*, at a minimum must be addressed in the proposal and implemented throughout the funding cycle.

Monthly, quarterly and year-end reports will be required of all grant recipients including data and billing collection, financial reporting, and program objective outcomes. A final year-end narrative report must describe how well the agency met the goals, objectives and service/work plan outlined in the proposal. The reports are subject to be used by both MDE and MDCH to assist in evaluating the effectiveness of programs funded under the state grants program and to report to the legislature. All reporting requirements, with required due dates and information detailing where to send reports, are outlined in *Attachment E.*

TECHNOLOGY REQUIREMENTS
Each funded applicant is required to have an accessible electronic mail account (email) to facilitate ongoing communication between MDE, MDCH and grantees. All funded grantees will be added to the State-funded list serve, which is the primary vehicle for communication between the State Departments and grantees.

Applicants providing clinical services must have the necessary technology and equipment to support billing and reimbursement from third party payers. Minimum Program Requirements #18, #19, and #20 (*Attachment C*) for both elementary and adolescent health centers describe the billing and reimbursement requirements for all grantees.

TECHNICAL ASSISTANCE AFTER AWARD NOTIFICATION
After notice of award, each newly funded CAHC will receive a site visit from a representative of the technical assistance team from MDCH for an on-site orientation and review of program expectations. Within the first two years, each newly funded CAHC will have a comprehensive site review scheduled to ensure that all minimum program requirements are being met and to

provide technical assistance to newly funded centers. After this initial site review, subsequent reviews will occur at least once every three years, or more frequently if deemed necessary.

Each successful planning grant applicant will receive a site visit from the technical assistance team from MDCH to assist in identifying areas of needed technical assistance. Once funded, successful planning grant applicants are required to work with the technical assistance team to give priority to and address areas of needed technical assistance and training including, but not limited to, administrative functions, governance, managed care/billing, billing systems, financial management, data management and clinical management. Each planning community will be assigned a *"Community Consultant"* from the technical assistance team to be a central point of contact for their community as the planning process is convened. These *Community Consultants* will periodically attend Community Advisory Council meetings for their assigned planning communities and facilitate any requests for technical assistance.

PART III: REVIEW PROCESS AND INFORMATION

PROPOSAL REVIEW PROCESS AND APPROVAL

All proposals will be reviewed jointly by MDE and MDCH and evaluated using a peer review system. Proposals must address all of the identified criteria and contain all requested information in the format laid out in this guidance. Award selections will be based on merit and quality as determined by points awarded for the Review Criteria Section and all relevant information. Rubrics will be used as a rating instrument in the review process and can be obtained from either Carrie Tarry at TarryC@michigan.gov or Elizabeth Coke Haller at HallerE@michigan.gov. The rubrics can also be downloaded from the MDE website. Each applicant will receive feedback including specific strengths, weaknesses, and recommendations based on their proposal. Successful applicants must respond to any conditions of funding within 30 days of receiving written notice of award. All funding will be subject to approval by the Superintendent of Public Instruction at the Michigan Department of Education and Director of the Michigan Department of Community Health.

ADDITIONAL REVIEW FACTORS

In addition to the review criteria in Part IV and Part V, MDE and MDCH may apply other factors in making funding decisions, such as: 1) geographical distribution; 2) gaps in services; 3) duplication of effort; 4) duplication of funding; 5) agency capacity; 6) evidence that an applicant has performed satisfactorily on previous projects; 7) schools not making adequate yearly progress; and 8) other factors relevant to addressing changing needs and populations.

BONUS POINTS

Bonus points will be awarded to applicants based on two criteria: Designation as an AYP School or School District and whether services are being proposed in one of the Governor's "Cool Cities". If a school based health center is proposing services in an AYP School or if a school-linked health center is proposing services in a school district with at least one AYP School, the applicant will receive 7 bonus points. If services are being proposed in one of the Governor's designated "Cool Cities", the applicant will receive 3 bonus points. *Please refer to Attachment B for specific definitions for AYP and the Cool Cities Initiative.* **The maximum number of bonus points an applicant can receive is 10 points total.**

GRANT REVIEWERS

MDE and MDCH will designate a panel of peer reviewers with extensive knowledge of the Child & Adolescent Health Center Program Requirements. The panel will consist of at least one representative from the Michigan Department of Education, Michigan Department of Community Health, Family Independence Agency, and Department of Labor and Economic Growth. There will also be at least one representative from a community partnership and one representative from an Intermediate School District or Local Education Agency. In addition, this review panel will receive training prior to reviewing proposals and will use a consensus process to enhance reviewer reliability of the final score. **Persons involved in the development of a proposal, associated with a district submitting a proposal, or having any other conflict of interest may not serve as reviewers.**

APPLICATION INSTRUCTIONS

- Application information, instructions and review criteria for the planning grants are detailed in Part IV of this application guidance.

- Application information, instructions and review criteria for clinical and non-clinical existing Child & Adolescent Health Center Grants are detailed in Part V of this application guidance.

If one organization is applying for more than one grant in different geographic locations or more than one model of funding, separate applications and budgets must be submitted.

PART IV: APPLICATION INFORMATION, INSTRUCTIONS, AND REVIEW CRITERIA FOR THE 2004-2005 SBSL-CAHC PLANNING GRANTS

Planning grants will be given a six-month planning phase that begins April 1, 2005 and ends September 30, 2005.

Support for funding for future years is contingent upon the availability of funds and successful program planning and readiness to implement programming. Training, technical assistance, and consultation during the planning phase will be provided by MDCH through the Adolescent Health Unit of the Division of Family and Community Health. MDE and MDCH will make final determinations on the number of planning communities that are selected to move forward in developing a clinical center. There is funding to support up to 10 communities to be invited to move forward with implementing a clinical CAHC.

PART A – COVER SHEET/APPLICATION (page 1 of the application)

The organization or agency submitting the proposal must be fully identified, as well as the direct contact person for this program. All boxes must be appropriately completed. The application requires an **original signature of the superintendent, director of the local education agency OR person with binding authority from the applicant agency**. Rubber stamps and copies are unacceptable.

Service Area. Complete the ***Service Area and Target Population Demographics Worksheet*** provided in *Attachment F*. This information is required. Proposals that do not have a completed worksheet included will not be reviewed.

Target Population. Identify the age group of the target population that will be served by the proposed project.

Children ages 5-10 (Elementary Age Population)
Youth ages 10-21 (Middle and High School Age Population and Young Adults)

PART B – ASSURANCES AND CERTIFICATIONS (page 1, 1a, 1b of the application)

The assurances and certifications for state and specific programs need an **original signature**. Rubber stamps and copies are unacceptable.

A total of 248 points are available for applicants applying for planning grants.

PART C – GRANT PROGRAM DETAILS (248 points)

1. Title Page. Provide the name and address of the applicant agency, federal identification number, name and telephone number of the authorized agent of the applicant agency, project director/coordinator name, address, telephone number, fax number and email address, and the

service/target area for which the proposal requests funds (school or school district, county, city, metropolitan area, etc.).

2. Table of Contents. Provide a table of contents with corresponding page numbers. Number each page of the proposal. Attachments should also be paginated and listed in the table of contents.

Proposal Narrative:

3. Preliminary Assessment of Needs/Assets among Your Community's Youth (60 points). Provide initial information on children or adolescent needs that will be addressed by a new school-based/school-linked health center. Complete the ***Need Statement Worksheet*** found in *Attachment G*. Provide a narrative description which incorporates, explains and expands upon this data. At a minimum, each applicant must provide a narrative explanation for four Barriers to Access and ten Health Disparity factors listed in the Need Statement Worksheet. Additional indicators of need that could be used to expand upon this data include, but are not limited to: federal designation as a Medically Underserved Area (MUA) and/or Medically Underserved Population (MUP); number enrolled and demographics of students attending the proposed school site/district; and local surveys depicting student needs/assets. Where possible, data should be as specific to the proposed geographic location of the SBSL-CAHC as possible. Include recent data, identifying the year and source of all data. Describe community resources available to meet youth health care needs and how a new SBSL-CAHC would be integrated with existing services and would fill gaps in current services.

Suggested resources for Michigan-specific data include:

- Michigan 2003 Youth Risk Behavior Survey, www.emc.cmich.edu/yrbs
- Michigan Department of Community Health Statistics and Reports, www.michigan.gov/mdch
- Michigan Department of Education, www.michigan.gov/mde
- Family Independence Agency, www.michigan.gov/fia
- Kids Count, 2004, http://www.milhs.org/information/default.asp?NavPageID=27455
- Michigan Primary Care Association, www.mpca.net

National resources for School Based Health Centers include:

- National Assembly on School-Based Health Care: www.nasbhc.org
- George Washington University, *Center for Health and Health Care in Schools*: www.healthinschools.org

Include the completed Need Statement Worksheet (Attachment G) as an attachment immediately following the budget forms.

Provide a map of the proposed service area as an attachment immediately following the Need Statement Worksheet.

4. Capacity and Readiness of Sponsoring Agency and Community (40 points). Provide a brief history of the sponsoring agency, including the agency's mission statement. How is the proposed project compatible with the agency's mission? What major linkages with public and private organizations, health care agencies, and school systems has this agency established through other initiatives? What other major initiatives have this agency managed? Provide rationale as to why this agency is appropriate to coordinate the SBSL-CAHC planning process.

5. Staffing Plan (10 Points). Provide a staffing plan, job description and, if available, the resume or vitae of staff assigned to coordinate the planning effort (those paid for by this grant, other funding sources and volunteers) noting existing staff as well as additional staffing needs. One individual must be designated as the program coordinator with sufficient authority, expertise and dedicated work time to carry out project activities.

6. Strength of Community Advisory Council (CAC) (20 points). Describe the extent to which key local partners involved, or proposed to be involved, in the CAC have had experience working together to improve the health of children and youth in the proposed area of need. Describe previous, existing or intended collaborative planning processes in the community that could be linked and coordinated with this planning effort. Describe any activities of the CAC in planning a SBSL-CAHC thus far, if applicable.

An array of school and community health programs and systems delivering health care to children in Michigan have overlapping target populations, purposes and services, which may not be well coordinated. To this end, successful grantees must include at a minimum the following partners in their planning:

- Administrators and staff from the school building in which services are proposed, if planning a *school-based* Child & Adolescent Health Center;
- School health program representatives (*minimum of 2*) such as: Coordinated School Health representatives, health education teacher, school nurse, social worker, psychologist, counselor, and/or special education teacher;
- Medical service providers from the proposed provider agency;
- Parents (One-third of the CAC must be comprised of parents of school-age children and youth (legislatively mandated, State Aid Act 2005, Section 31a(6));
- Youth from the target population (if an adolescent site is being proposed); and
- Local public health department.

Consider including these additional representatives on your CAC: superintendent, school board members, building principals, school health coordinator, sex education supervisor, local community health, mental health, substance abuse, community collaborative bodies, and dental providers; faith-based organizations; Parent/Teacher Association or Organization (PTA/PTO), and other youth-serving agencies. Proposals are further strengthened by support from broad community representatives who are actively involved in the planning process. Applicants located in school districts that already have one or more SBSL-CAHC should describe how they will coordinate with the operational center(s).

Provide an initial roster of proposed or existing CAC members as an attachment immediately following the map of the proposed service area.

7. Barriers/Assets of the Community (20 points). Identify any anticipated barriers that might arise during the planning process. How will these barriers be addressed during the planning process? Identify any unique assets that your community/school has that will aid in the planning process. How will these assets/strengths be capitalized on to strengthen planning in this community? Please note that applicants will not be penalized for listing barriers in their community. The identification of any anticipated or real barriers will help strengthen local planning efforts and will assist the Technical Assistance Team at MDCH in providing tailored technical assistance that will help address these barriers.

8. Work plan (40 points). This section is subdivided into two pertinent areas: *Required Goal and Objectives for Planning Grantees* and *Required Reports and Trainings for Planning Grantees:*

Each planning grant work plan will have the same goal and six required objectives, which are detailed below. These objectives have been based on the outcomes expected at the end of the planning period. **Applicants are encouraged to add additional objectives that are tailored to the community and reflect the community's progress in the planning process.** Additional objectives should be SMART (Specific, Measurable, Appropriate, Realistic and Time-phased) and be based on the steps the community/school needs to take to accomplish its projected outcomes.

Plans and activities for achieving all objectives should be fully integrated into the work plan. Within the work plan, proposed key activities should be fully and clearly described for the period **April 1, 2005, through September 30, 2005**. Each key activity must have a **documented and quantifiable outcome (process or product)**. The **source or method** of documentation of achievement of each key activity and outcome should be identified. The **projected date of completion** for each key activity and outcome should be clearly stated. The **person(s) responsible for completion** of each key activity should be identified.

Work plans *must* follow the format outlined in Attachment H.

Required Goal and Objectives for Planning Grantees:

Goal: By October 1, 2005, document the need and demonstrate the readiness and support of the community/school for instituting a clinical school-based or school-linked child and adolescent health center.

Objective 1: By May 1, a ***Community Advisory Council*** (CAC) will be formed or designated.

Objective 2: By June 30, a needs assessment of the health needs of the target population will be completed.

Objective 3: By July 30, services to be offered in the SBSL-CAHC that are responsive to both the minimum program requirements and to the health needs of the target population will be identified.

Objective 4: By August 15, school system and/or sponsoring agency approval and in-kind support, as well as other community resources and funding support, will be committed and documented.

Objective 5: By September 1, a location in which to provide the SBSL-CAHC services in the community will be identified and secured.

Objective 6: By September 1, a plan of operation will be developed and submitted to MDCH and MDE for approval, which identifies next steps with a timeline for initiating a CAHC.

Please note that if your community has already achieved one or more of the mandatory objectives through an existing planning process, please describe this in your work plan and include any documentation and/or evidence of completion as attachments. MDCH and MDE reserve the right to determine the extent to which the provided documentation fulfills the requirements of the objectives.

Required Reports and Trainings for Planning Grantees:

The following reports and trainings are required of all planning communities and should be integrated into the work plan and budget as needed.

Reporting Requirements

- Narrative progress reports are due June 1st and August 1, 2005.
- Final report, which includes an implementation plan for FY05-06, is due September 1, 2005.

Required Trainings and Technical Assistance

- A minimum of 3-5 members of your CAC must attend and participate in technical assistance and training provided by MDCH in the **Spring/Summer 2005**.
- A minimum of 3-5 members of your CAC must attend a workshop on "*How to Plan a School-Based Health Center*," in **April 2005** at a metro Lansing location to learn about conducting a needs assessment, putting together component services, and financing and implementing action strategies.
- The CAC must designate at least two persons to attend the National Assembly on School-Based Health Care (NASBHC) Convention on **June 16-18 2005** in Rhode Island**.**

The proposed budget for the planning grant must reflect these required trainings and workshops.

9. Medicaid Outreach Plan (10 points). Due to funding guidelines, each planning community must provide Medicaid Outreach activities to eligible children and youth in their service area throughout the planning process. A preliminary plan with proposed activities should be included at the end of the work plan. **For a list of eligible activities, refer to MSA 04-13, which is included in Attachment I.**

Eligible activities might include the following: providing Medicaid applications to any child or youth focus group or forum that is being conducted as part of the planning process as a strategy for documenting need; providing Medicaid applications to any parent groups that are sought out during the planning process; provide CAC members with Medicaid brochures to take back to their respective agencies for dissemination; setting aside CAC meeting time to discuss how to strengthen outreach efforts in the community and/or school, etc.

MDCH will provide technical assistance to successful applicants regarding how to integrate Medicaid Outreach activities into the planning process after funds are awarded.

10. Michigan State Board of Education Strategic Goal and Strategic Initiatives (10 points). The State Board of Education has adopted as its Strategic Goal, "Attain substantial and meaningful improvement in academic achievement for all students/children, with primary emphasis on chronically under performing schools and students." In addition, the State Board has adopted the following five Strategic Initiatives to implement the goal:

A. Ensuring Excellent Educators,
B. Elevating Educational Leadership,
C. Embracing the Information Age,
D. Ensuring Childhood Literacy, and
E. Integrating Communities and Schools.

Explain how *one or more* of the Michigan State Board of Education's five strategic initiatives will be addressed through your community's planning process. Please limit the response to **not more than ONE** typed sheet.

11. Letters of Commitment (10 points). Letters of commitment to participate from the **superintendent or building principal and the local public health department are required**. Provide a minimum of 3 additional letters of commitment/support from potential or actual partners who will work with you on this planning effort. Letters should demonstrate strong evidence of community support for the planning process. **Letters should be included as attachments immediately following the initial roster of Community Advisory Council members.**

12. Letters of Need (8 points). Current letters documenting the lack of services must be obtained from at least three (3) of the following agencies: community mental health, local office of substance abuse services, federally qualified health centers (FQHCs), local Family Independence Agency (FIA), local hospital, Mayor's office, county health department board or commissioners, school district superintendent or school board, intermediate school district, and/or local public health department. **One of the three letters must come from the local Community Collaborative** (Multi-purpose Collaborative Bodies) operating in your service area. (*If these letters also contain statements supporting the planning process and indicate a commitment to participate in the process, they will contribute to the requirements under #11. Letters of Commitment.*) **Letters should be included as attachments immediately following the Letters of Commitment.**

13. Financial Plan (20 points). Planning grant requests must not exceed $75,000.
Applicants may request an amount up to $75,000. When determining the size of your request, consider such factors as: past or current planning efforts that dealt specifically with starting a SBSL-CAHC; complexities in local partnerships; amount of work to be accomplished; and other local conditions. The financial plan should be sufficient to achieve the proposed project, but not be excessive. **A minimum local match of 30 percent of the amount requested is required.** The match can be reached either through cash contributions (hard match) or in-kind resources such as donated space or time (soft-match). The Financial Plan should also describe all funding sources and the distribution of these funds as they relate to supporting the proposed planning process.

PART E: Budget

1. **Budget Forms**: Prepare a line-item budget for the period of April 1, 2005, through September 30, 2005 on the Budget Summary and Cost Detail forms for the amount requested (*forms and instructions -Attachment J*). All in-kind resources and hard match must also be included on the budget.

    a. The budget should designate a person (or position) to spend time each week coordinating the planning effort.

    b. The budget should also include funds for a team of 3-5 persons from the CAC to travel to Lansing for up to two workshops in Spring/Summer of 2005.

    c. Additionally, the budget should include up to $2,500 for a minimum of two representatives to attend the National Assembly on School-Based Health Care convention, June 16-18 2005 in Rhode Island.

2. **Budget Narrative**: The budget narrative must provide a detailed description of planned expenditures, including justification and rationale. All budget line items must be described in the budget narrative *(Guidelines for the Budget Narrative are found in Attachment K*).

    a. If your agency is funded to provide services similar or related to those proposed in this application, provide a list of those funders, amount of award, contract period, and services supported.

3. **Eligible Expenditures**:

    a. Planning Grant funds MUST be used to pay for the following expenditures:
        1. Medicaid Outreach Activities to eligible children, youth, and families

b. Planning Grant funds MAY be used to pay for the following expenditures:
    1. Materials and supplies
    2. Coordinator/director, manager, and secretarial support salary and fringes
    3. Contractual staff and/or consultants hired to facilitate the planning process
    4. Parent/youth involvement activities
    5. Staff development and teacher/parent training
    6. Travel necessary to enable project staff to implement the program's goals and objectives
    7. Communication
    8. Meeting and training supplies and materials
    9. Stipends and substitute reimbursements (if needed)

c. Planning grant funds **MAY NOT** be used to pay for:
    1. Indirect costs
    2. Capitol costs

Complete the Application Checklist and Fax Back Form for planning grant applicants (Attachment D).

Part V: APPLICATION INFORMATION, INSTRUCTIONS, AND REVIEW CRITERIA FOR EXISTING CLINICAL AND NON-CLINICAL CHILD & ADOLESCENT HEALTH CENTER GRANTS

REVIEW CRITERIA

All applicants will be evaluated on the basis of the criteria described in this section. Narrative sections of the applications should address each criterion. Applications are not to include pamphlets, handbooks, reports, brochures, news articles, folders, binders, dividers, etc. **Two hundred eighty** is the maximum score that can be obtained for this application, and the value assigned for each section is indicated. Points will be deducted for any proposal narrative that exceeds the 30 written pages allowed in Part C. Required forms and support documents (title page, table of contents, certifications and assurances, list of advisory council members, budget forms, budget narrative, work plan, interagency agreement with school, and letters of commitment and need) are not counted in the narrative page limit.

PART A – APPLICATION COVER SHEET/APPLICATION (Page 1 of the Application)

The organization or agency submitting the application must be fully identified, as well as the direct contact person for this program. All boxes are to be accurately completed. The application requires an original signature of the superintendent, director of the local education agency, OR person with binding authority from the applicant agency. *Rubber stamps and copies are unacceptable.*

1. **Funding Strategy.** Identify the type of program the applicant requests funds (clinical or non-clinical), and the amount of funds requested.

   a. **Clinical Child & Adolescent Health Center Model*:**

   School Based Health Center Model - $175,000

   School Linked Health Center Model - $225,000

   Federally Qualified Health Center (School Based or School Linked) - $175,000

   ***Clinical CAHCs must reach a minimum of 500 unduplicated children or youth annually.** Applicants must also identify the total number of children and/or youth in the service area. This information will be used to determine a minimum number of users to be served by each applicant. For centers that have received or are currently receiving State funding, previous data reports will be utilized to determine the unduplicated number of children and youth that need to be served annually by the grantee. This number will vary depending on the grantee and the unique geographic characteristics of the service area.

   b. **Non-Clinical Adolescent Health Center Model**:

   Non-clinical Adolescent Health Model: $85,000

2. **Service Area.** Identify the service/target area the requested funds will service (school district, county, city, metropolitan area etc.).

3. **Target Population**. Identify the age group of the target population that will be served by the proposed project. **Please identify the primary age group that will be served**.

Children ages 5-10 (Elementary Age Population)

*Youth ages 10-21 (Middle and High School Age Population and Young Adults)

**Non-clinical health centers must serve the 10-21 year old adolescent population.*

Please note that there are separate Minimum Program Requirements (MPRs) for clinical centers serving the 5-10 year old population versus centers serving the 10-21 year old population. If the grantee plans on serving both age groups, they must adhere to both MPRs, which are included in *Attachment C*. Please also note that if the Adolescent (10-21 year old) population is being served, the applicant must provide a teen-friendly clinic atmosphere that is both acceptable and accessible to this population. *Serving young children must not pose a barrier to the teen population accessing this center.* Applicants are encouraged to choose one of the age groups listed above. Please note that if the majority of clients served fit in one of the two age groups, please only check the age group that encompasses the majority of the population that will be accessing this center. If both populations are proposed to be served equally, the applicant must provide a detailed description of how they will ensure that the teen population will view this clinic as accessible and acceptable.

PART B - ASSURANCES AND CERTIFICATIONS (Page 1, 1a, 1b of the application)
The assurances and certifications for state and specific programs need an original signature. Rubber stamps and copies are unacceptable. See *Attachment C* for required objectives outlined in the Minimum Program Requirements.

PART C – GRANT PROGRAM DETAILS (**280 POINTS**)

1. **Table of Contents.** Provide a table of contents with corresponding page numbers on each page of the application. Attachments should be paginated and listed in the table of contents.

2. **Project Abstract/Summary (10 points).** Provide NO MORE THAN A THREE PAGE, single-spaced summary of the proposal. Explain briefly:
    A. Organization's history of administering programming for which this application requests funds;
    B. Statement of need for the proposed program, the target area and population the program will serve, and the number of unduplicated children and/or youth expected to be reached in the first year of funding;
    C. A summary of the major program goals and expected outcomes;
    D. A brief description of the proposed programming including a description of where services will be provided (if a clinical model, include a brief description of the clinic space);
    E. Total amount of local resources which will be applied to the project and how they will be used (30% local match requirement); and
    F. Highlight key people who will be involved with the project.

3. **Assessment of Need (60 points).** The proposal must include documentation from multiple sources on the lack of accessible and child or youth-acceptable services in the geographic

area proposed to be served. The need/demand for services must be well documented. **Proposals failing to meet these criteria will not be considered for funding.**

A. Provide a map of the proposed service area

B. Provide descriptive and demographic information of the service area including:
   1. Service area definition
   2. Economic status of the population
   3. Other agencies providing similar services as those proposed
   4. Data on estimated need/demand for the proposed services
   5. Adequate Yearly Progress Designation (school site or coming from a district with AYP schools)
   6. Description of other unusual factors affecting the need for the proposed services

C. Describe the characteristics of the target population including:
   1. Size of the target population
   2. Age of the target population (applicants are encouraged to select either the 5-10 year old population or the 10-21 year old population; if both populations will be equally served, please provide a detailed explanation for how teen-friendly services will be provided that are both accessible and acceptable to this 10-21 year old age group)
   3. Economic status of the target population (at a minimum, include number of children or youth in the target population that receive free or reduced price school lunch)
   4. Sex and racial make-up of the target population
   5. Health status and level of risk-taking behaviors

D. Identify and include the results of a health survey that has been conducted in the previous three years to assess the target population's health needs.

E. Current letters documenting the lack of services must be obtained from at least three (3) of the following agencies: community mental health, local office of substance abuse services, federally qualified health centers (FQHCs), local Family Independence Agency (FIA), local hospital, Mayor's office, county health department board or commissioners, school district superintendent or school board, intermediate school district and/or local public health department. **One of the three letters must come from the local Community Collaborative** (Multi-purpose Collaborative Bodies) operating in your service area. (*If these letters also contain statements supporting the proposal and the applicant's ability to accomplish the proposal, they will contribute to the requirements under "5. Community Collaboration/Support*.")

4. Community Experience (30 points). Briefly describe the community's historical commitment to the proposed program as well as its support for school-based/school-linked health services for the adolescent population (if adolescents are proposed to be served) or young children (if the 5-10 year old age group is to be served). For applicants proposing non-clinical adolescent health services, describe the community's historical commitment to providing non-clinical services to the adolescent population. Provide evidence of the applicant organization's

ability to accomplish the proposed service/work plan and manage a grant program of similar size and complexity. Include a description of services provided by the applicant organization, which are similar to or which compliment the proposed services. Finally, briefly summarize the applicant's present or past experience mobilizing, establishing and maintaining a community-based, broadly representative local advisory committee with a health-related mission.

5. Community Collaboration/Support (30 points). The proposal should demonstrate the support of other related service providers and the general community. Provide a description of the available community resources, which will help sustain the proposed program (both hard match and/or in-kind services).

Provide a listing of collaborative and referral arrangements which will be utilized for the proposed programming. The listing should include, at a minimum, other programs that provide similar or related services to the target population and how the proposed program will interact with (i.e. refer to and/or accept referrals from) these organizations but not duplicate efforts.

Provide a minimum of five (5) letters of endorsement for the proposal which indicate that other agencies and the general community believe the applicant agency is able to successfully accomplish the proposed program, that the program will meet the described needs and what they are willing to contribute toward the support of the program. Evidence of the involvement of local agencies or community members in the proposed program should also be included**. A letter of support from the local health department is required for consideration of this proposal.**

6. Advisory Committee Structure, Membership and Activity (15 points). Describe the current or proposed structure of the committee including membership, leadership, sub-committees, activities, procedures for developing/approving policy and frequency of meetings. See Minimum Program Requirement #14 for both Elementary and Adolescent Clinical Health Centers and MPR #1 for Non-clinical Health Centers for specific regulations regarding the composition of the membership, frequency of meetings and policy requirements. *Please note that at least 1/3 of the membership must be composed of parents of school-aged children and youth.* Provide a copy of the existing or the potential advisory committee membership list in the attachments. Outline the plan to recruit and maintain diverse members that are representative of the racial, ethnic, economic and philosophical diversity of the target area.

If policies and procedures on the following topics already exist and have been approved by the advisory committee, include them as attachments to the proposal:

- ✓ Parental consent.
- ✓ Requests for medical records and release of information that include the role of the non-custodial parent and parents with joint custody.
- ✓ Confidential services (*clinical services only*).
- ✓ Disclosure by clients or evidence of child physical or sexual abuse and/or neglect.

7. Organizational Structure (25 points). Describe the administrative and organizational structure within which the program and the advisory committee will function. Submit as an attachment an organizational chart depicting the program, including the advisory committee, the

fiduciary agency, program coordinator, proposed subcontractors (if applicable) and all related program personnel.

Describe the number of staff and/or volunteers who will provide the proposed services including a description of the skills/qualifications necessary. Include in the attachments job descriptions or vitae (if available) of the personnel who will play key roles in the administration of the project and the delivery of services. See the attached minimum program requirements for a description of required providers and clinical hours of operation (MPR #10, #11, and #12 for Adolescent Health Centers and MPR # 9, #10, #11, and #12 for Elementary Centers). Provide a description of how program coordination will occur, including any full-time equivalents (FTEs) dedicated to overseeing and coordinating administrative functions. Briefly describe the staff development opportunities that will be made available to the staff or required of them.

8. Service Plan Narrative (50 points). Services proposed to be provided should be fully and clearly described for the period **October 1, 2005 through September 30, 2006**. For centers that currently do not receive state funding, please provide a service/work plan for this time period as well. *If selected for funding, these centers will be asked to submit an additional 6-month service/work plan for the period of April 1, 2005 – September 30, 2005*.

The services as described in this proposal must be operational and accessible to the described target population by October 1, 2005.

A. Provide a description of the services provided at the center or through non-clinical services.

B. Describe the case finding system (i.e. how clients will be identified and recruited).

C. Describe the referral system.

D. For clinical health center applicants, describe the hours of operation and arrangements for after-hours coverage.

E. Indicate the number of unduplicated children and/or youth to be served in the course of the fiscal year**. If clinical services are being provided, a minimum of 500 unduplicated users must be proposed and served.** Please note that a minimum number of users will be negotiated with MDCH for FY05-06 for each grantee and will take into account a number of factors including, the proposed number of users included in the work plan, size of service area and historical utilization numbers.

F. Describe where and how services will be provided. If the selected site is a location other than on school property, justify the accessibility of the site for the target population. **If the selected site is on school property, a copy of an interagency agreement between the sponsoring agency and the local school district must be included with the proposal, which defines roles and responsibilities.**

G. If clinical services are being proposed, describe the layout of the clinical space including dimensions, handicapped accessibility and how services will be provided in a confidential manner, including records.

H. Briefly describe the organization's plan to comply with Occupational Safety and Health Act (OSHA) guidelines regarding transmission of blood borne pathogens, and laboratory guidelines, if applicable.

I. If services will be provided on school property, written approval by the school administration and the local school board must be submitted with the proposal for the following items:

- ✓ Location of the health center (both clinical and non-clinical models).
- ✓ Administration of a health survey to students enrolled in the school.
- ✓ Parental consent policy.
- ✓ Services rendered in the health center program.

J. Describe the applicant organization's plans to assure that quality services are provided through this program. See *Attachment C*, Minimum Program Requirements (MPRs), for a description of the required components of a quality assurance plan. *Please note that there are separate MPRs for clinical centers serving the elementary age population versus clinical centers serving the adolescent and young adult population. Non-clinical MPRs are directly following the clinical adolescent health MPRs in Attachment C.*

K. Describe how your agency will provide Medicaid Outreach activities and facilitate access to Medicaid preventive services to eligible children and youth in your target area. The outreach plan should also describe how eligible children and youth will be identified. Clinical CAHCs must follow Activities 1-5 as outlined in **Medicaid Bulletin 04-13**, which is included in *Attachment I*. Non-Clinical Adolescent Health Centers must provide Activities 1, 2, and 5. **In the work plan, at least one goal must be included, with measurable objectives and activities related to Medicaid Outreach and facilitating access to Medicaid preventive screenings**.

L. Describe how youth input will occur, if providing services to the adolescent population. For elementary centers, describe how the health needs of children in the service area will be integrated into the center's service delivery plan and describe how parents will be involved at the center.

M. Describe how the program will be evaluated, such as goals and measurable objectives, client satisfaction surveys, focus groups or other methodologies.

9. **Work Plan (25 points).** List the overall program goal(s), and measurable, time-framed objectives using the required format included in *Attachment H.* Objectives should be SMART (Specific, Measurable, Appropriate, Realistic and Time-phased) and address the needs of the target population. If providing services to the adolescent population, describe how youth input will occur and how services will be youth-friendly and acceptable to youth. When completing

this section, **carefully review the Minimum Program Requirements included in Attachment C.** It is imperative that the required services addressed in the attached Minimum Program Requirements (MPR #1 and #2) are specifically addressed.

Mandatory Focus Areas - Each work plan should include at least 2 of the following mandatory areas of focus. Each focus area should have a goal with corresponding objectives and activities that outline your center's plan for addressing the focus area. Centers are encouraged to look at the needs of the target population when determining which areas of focus will be selected for FY05-06.

FY05-06 Mandatory Focus Areas (*select at least 2*):

1. **Outreach to Schools not meeting Adequate Yearly Progress (AYP)** – address how your center will provide outreach and/or services to failing schools that fall in your target area.
2. **Pregnancy Prevention** – address any efforts your center will undertake to reduce or impact teen pregnancy prevention.
3. **Obesity/Nutrition/Physical Activity** – address how your center will impact youth obesity and promote nutrition and physical activity to high-risk youth.
4. **HIV/AIDS** – address how your center will provide either education on HIV/AIDS; outreach, referral, and/or access to confidential HIV counseling and testing; and/or risk reduction to high-risk youth.
5. **Tobacco Prevention/Cessation**– address any efforts your center will undertake to impact tobacco use among youth.

10. Michigan State Board of Education Grant Strategic Goal and Strategic Initiatives (10 points). The State Board of Education has adopted as its Strategic Goal "Attain substantial and meaningful improvement in academic achievement for all students, with primary emphasis on chronically under-performing schools." In addition, the State Board has adopted the following five Strategic Initiatives to implement the goal:

A. Ensuring Excellent Educators,
B. Elevating Educational Leadership,
C. Embracing the Information Age,
D. Ensuring Childhood Literacy, and
E. Integrating Communities and Schools.

Explain how *one or more* of the Michigan State Board of Education five strategic initiatives will be addressed through the Child and Adolescent Health Center Grant. Please limit the response to **not more than ONE** typed sheet. To learn more about the five Strategic Initiatives and download the Task Force reports go www.michigan.gov/mde and click on State Board of Education.

11. Financial Plan (25 points). The financial plan should be sufficient to achieve the proposed project, but not be excessive. **A minimum local match of 30% of the amount requested is required.** The match can be reached either through cash contributions (hard match) or in-kind

resources such as donated space or time (soft-match). The financial plan should also address the following:

A. Briefly describe all funding sources and the distribution of these funds (*Clinical and Non-clinical AHCs*).

B. For existing centers that are not currently funded by the State, this funding must not be used to supplant current funding supporting clinic services. Please detail how this funding will be used to expand on the existing financial support of the center and not supplant current funding streams.

C. Describe the fee schedule and how it will be applied (see minimum program requirements for CAHCs, which address that services cannot be denied because of inability to pay). *(Clinical CAHCs only)*

D. Describe the billing system that will be used to recover appropriate revenues from third-party payers, if applicable (*Clinical CAHCs only*).

E. Describe how the billing and fee collection processes protect client confidentiality (*Clinical CAHCs only*).

PART D: BUDGET

12. Budget Forms: Prepare a line-item budget for the period of October 1, 2005 through September 30, 2006 on the **Budget Summary** and **Cost Detail Forms** for the amount requested (*forms and instructions – Attachment J*). All in-kind resources and hard match must also be included on the budget. Please note that for centers not currently receiving state funding that are awarded a grant through this competitive process, an additional budget will be required after the notification of awards for the period of April 1 – September 30, 2004.

13. Budget Narrative: Budget narratives must provide detailed descriptions of planned expenditures, including justification and rationale. All budget line items must be described in the budget narrative (*Guidelines for the Budget Narrative are found in Attachment K*).

A. If your agency is currently funded to provide services similar or related to those proposed in this application, provide a list of the funding source(s), amount of award, contract period, and services supported.

Attachment A

SECTION 31a, SUBSECTION 6
OF THE
STATE SCHOOL AID ACT

(6) From the funds allocated under subsection (1), there is allocated for 2001-2002 an amount not to exceed $2,400,000 to support SBSL-CAHCs. These 2001-2002 funds shall be distributed to existing SBSL-CAHCs in a manner determined by the department in collaboration with the Department of Community Health. From the funds allocated under subsection (1), there is allocated each fiscal year for 2002-2003 and for 2003-2004 an amount not to exceed $3,743,000 for competitive grants to support SBSL-CAHCs. These grants for 2002-2003 and 2003-2004 shall be awarded in a form and manner approved jointly by the department and the Department of Community Health. If any funds allocated under this subsection are not used for the purposes of this subsection for the fiscal year in which they are allocated, those unused funds shall be used that fiscal year to avoid or minimize any proration that would otherwise be required under subsection (11) for that fiscal year.

Attachment B

Key Terms and Definitions for Child & Adolescent Health Center Competitive Process:

ADEQUATE YEARLY PROGRESS (AYP): is defined as one of the cornerstones of the federal No Child Left Behind (NCLB) Act. In Michigan, it is a measure of year-to-year student achievement of the Michigan Education Assessment Program (MEAP) test. Michigan and other states must raise the bar in gradual increments to meet the target that 100% of the student's in the State are proficient on state assessments by the 2013-2014 school year. AYP applies to each district and school in the state. For an updated list of AYP schools and/or districts, go to www.michigan.gov/mde.

COOL CITIES INITIATIVE: is defined as a Michigan Initiative committed to the growth, revitalization and momentum of our communities that adheres to the following guiding principles: support innovation, grow our talent, embrace diversity, invest in and build of quality of place, think regionally and act locally, and making new connections. Select cities in Michigan have been funded through the "Cool Cities Initiative". For a list of Cool Cities, go to www.coolcities.com.

EXISTING CENTER: is defined as a center that is currently operational and able to meet State-defined Minimum Program Requirements (MPRs) **OR** a center with the capacity to become operational and able to meet State-defined MPRs within 90 days of the start of the contract.

NON-CLINICAL CENTER: is defined as a center that provides services in the community or on school property that focuses on the local health needs of adolescents. A non-clinical center can provide limited clinical care, health screenings, case finding and referral, Medicaid Outreach and enrollment, and health education. The non-clinical adolescent health center must operate throughout the year and must follow School Code regulations if services occur on school property.

PLANNING COMMUNITY: is defined as a community interested in convening a planning process to determine the feasibility of establishing a new clinical Child & Adolescent Health Center, a community that is in the process of planning, **OR** has undergone a planning effort but is not able to meet State-defined MPRs within 90 days of the start of the contract.

SCHOOL BASED HEALTH CENTER: is defined as a health center located in a school or on school grounds that provides on-site comprehensive primary and preventative health services, including referrals, tracking and follow-up, throughout the year with signed agreements with the host school and/or local school district. The SBHC is expected to operate at least 30 hours per week and provide 24-hour backup coverage to all students and users enrolled in the SBHC. The 30 hours of clinic services must be provided by a certified Nurse Practitioner (PNP, FNP, SNP), Physician Assistant, or a Physician. School Based Health Centers can be located in elementary, middle, high, or alternative schools and must follow School Code Regulations.

SCHOOL LINKED HEALTH CENTER: is defined as a health center NOT LOCATED ON SCHOOL PROPERTY that provides on-site comprehensive primary and preventative health services, including referrals, tracking and follow-up, throughout the year to adolescents and young adults. A school-linked health center is located in the community at an accessible location and has strong ties to area schools. A school-linked health center is expected to operate at least 30 hours per week and provide 24-hour backup coverage to all adolescents, young adults and users enrolled in the center. The 30 hours of clinic services must be provided by a certified Nurse Practitioner (PNP, SNP, FNP), Physician Assistant, or a Physician. A school-linked health center does not have to follow School Code Regulations. School-linked health centers provide services to youth ages 10-21 and the small children of the adolescent population.

SERVICE AREA: is defined as a geographic area with precise boundaries (e.g. school district, county). The size of the service area should be appropriate to provide services in a timely and appropriate fashion.

TARGET POPULATION: is defined as a subset of the entire service area population (e.g. school building, city, or other). For the purpose of this program, the eligible target population is 5-21 year olds and the small children of the adolescent population. The description of the target population should include the major health problems of the target population and should serve as the basis for the center's service delivery plan.

Attachment C

MINIMUM PROGRAM REQUIREMENTS FOR ADOLESCENT HEALTH CENTER PROGRAM

ELEMENT DEFINITION:

Services designed specifically for persons 11 through 21 years of age aimed at achieving the best possible physical, intellectual, and emotional status. Included in this element are: 1) Adolescent Health Centers designed to provide primary care, psychosocial and health promotion/disease prevention, and outreach services. The infants and small children of the target age group can be served through this program; and 2) Non-clinical Adolescent Health Centers designed to provide health education, peer counseling, screening/case finding services, referral for primary and/or specialty care, limited clinical services, outreach services and/or health related community awareness activities.

MINIMUM PROGRAM REQUIREMENTS FOR CLINICAL ADOLESCENT HEALTH CENTERS:

Services

1. The adolescent health center shall provide a range of support services that are high quality, acceptable and accessible to youth in their target population. The adolescent health center shall provide a minimum of two of the following thirteen teen specific support services: mental health counseling, drug/alcohol awareness, support groups, smoking cessation programs, sexual abuse counseling, tutoring, job skills training, suicide prevention programs, support for eating disorders, nutritional counseling, teen advisory groups, parenting education, support for intimate partner violence, and peer education and counseling.

2. The adolescent health center shall provide a range of services based on the needs determined through the adolescent health survey, and approved by the advisory committee. At a minimum the services shall include immunization screening and administration with the utilization of the Michigan Childhood Immunization Registry, primary care including health maintenance (well care), EPSDT screening, and care for acute illness and chronic conditions, referral for other needed clinical services not available at the teen health center, HIV and STD education, and voluntary counseling and testing, and shall follow preventive services guidelines (such as GAPS or Bright Futures).

3. The adolescent health center shall not, as part of the services offered, provide abortion counseling, services, or make referrals for abortion services.

4. The clinical services provided shall meet the recognized, current standards of practice for care and treatment of adolescents and their children.

5. The adolescent health center, if on school property, shall not prescribe, dispense, or otherwise distribute family planning drugs and/or devices.

6. The adolescent health center shall provide Medicaid outreach services to eligible youth and families and shall adhere to Child and Adolescent Health Centers and Programs (CAHCPs) outreach activities as outlined in MSA 04-13.

Administrative

7. Written approval by the school administration and local school board exists for the following:

   a) location of the health center if located on school property or in a building where K-12 education is provided;
   b) administration of a health survey to students enrolled in the school;
   c) parental consent policy if services are provided in a building where K-12 education is provided;
   d) services rendered in the health center if the center is located on school property where K-12 education is provided.

8. If the health center is located on school property, it shall have a current interagency agreement defining roles and responsibilities between the contracting agency and the local school district.

9. The adolescent health center shall be located in a school building or an easily accessible alternate location.

10. The health center shall be open during hours accessible to its target population, and provisions must be in place for the same services to be delivered during times when school is not in session. Not in session refers to times of the year when schools are closed for extended periods, such as holiday, spring breaks, and summer vacation. These provisions shall be either posted, given to and/or explained to clients including at a minimum an answering service/machine message. The center shall provide clinical services a minimum of five days a week. Total provider clinical time shall be at least 30 hours per week. Hours of operation must be posted in areas frequented by the target population. The adolescent health center shall have a written plan for after-hours and weekend care, which shall either be posted, given to, and/or explained to clients.

11. The adolescent health center shall have a licensed physician as a medical director who supervises the medical services provided. Written standing orders and clinical procedures approved by the medical director and the contracting agency shall be available for use by clinical staff.

12. The health center shall be staffed by a certified nurse practitioner (Pediatric Nurse Practitioner (PNP), Family Nurse Practitioner (FNP), or School Nurse Practitioner (SNP)), licensed physician, or a licensed physicians assistant working under the supervision of a

physician during all hours of clinic operation. The nurse practitioner must be certified or eligible for certification in Michigan and accredited by an appropriate national certification association or board. The physician and physician assistant must be licensed to practice in Michigan.

13. The health center shall implement a quality assurance plan. Components of the plan shall include at a minimum:
    a) ongoing clinical and medical records reviews by peers to determine that conformity exists with current standards of practice. A system shall also be in place to implement corrective actions when deficiencies are noted.
    b) completing, updating, or having access to an adolescent health survey/assessment done within the last two to three years to determine the health needs of the target population.
    c) conducting a client satisfaction survey/assessment periodically, but no less than once per year.

14. A local advisory committee shall be established and operated as follows:
    a) A minimum of two meetings per year.
    b) The committee must be representative of the community and must be comprised of at least 50% members of the community; two-thirds of members must be parents of school-aged children and youth.
    c) Health care providers shall not represent more than 50% of the committee.
    d) The committee should recommend the implementation and types of services rendered by an adolescent health center.
    e) The advisory committee must approve the following policies and the adolescent health center must develop applicable procedures:

        1. Parental consent;
        2. Requests for medical records and release of information that include the role of the noncustodial parent and parents with joint custody;
        3. Confidential services; and
        4. Disclosure by clients or evidence of child physical or sexual abuse, and/or neglect

15. The health center shall have space and equipment adequate for private physical examinations, private counseling, reception, laboratory services, secured storage for supplies and equipment, and secure paper and electronic client records. The physical facility must be barrier-free, clean, and safe.

16. The health center staff shall follow all Occupational Safety and Health Act guidelines regarding transmission of blood borne pathogens, such as HIV and Hepatitis B, to health care and Public Safety Workers.

17. The health center shall conform to the regulations determined by the Department of Health and Human Services for laboratory standards.

Billing and Fee Collection

18. The adolescent health center shall establish and implement a sliding fee scale, which is not a barrier to health care for teens. Adolescents must not be denied services because of inability to pay.

19. The adolescent health center shall establish and implement a process for billing Medicaid, Medicaid Health Plans and other third party payers.

20. The billing and fee collection processes do not breach the confidentiality of the client.

MINIMUM PROGRAM REQUIREMENTS FOR NON-CLINICAL ADOLESCENT HEATLH CENTERS:

1. A local advisory committee shall be established and operated as follows:
    a) A minimum of two meetings per year.
    b) The committee must be representative of the community and must be comprised of at least 50% members of the community; two-thirds of members must be parents of school-aged children and youth.
    c) Health care providers shall not represent more than 50% of the committee.
    d) The committee should recommend the implementation and types of services rendered by a non-clinical adolescent health center.
    e) The advisory committee must approve the following policies and the non-clinical teen health center must develop applicable procedures regarding:
        1. Parental consent;
        2. Requests for medical records and release of information that include the role of the noncustodial parent and parents with joint custody; and
        3. Disclosure of clients or evidence of child physical or sexual abuse, and/or neglect.

2. The non-clinical adolescent health center shall provide a range of services based on the needs of the target population. The non-clinical adolescent health center shall complete, update or have access to an adolescent health survey/assessment done within the last two to three years to determine the needs of the target population.

3. If clinical services are provided, they shall meet the recognized, current standards of practice for care and treatment of adolescents and their children.

4. The non-clinical health center shall not, as part of the services offered, provide abortion counseling, services, or make referrals for abortion services.

5. The non-clinical health center, when operating on school property, shall not prescribe, dispense or otherwise distribute family planning drugs or devices.

6. The non-clinical adolescent health center shall provide Medicaid outreach services to eligible youth and families and at a minimum, shall adhere to Child and Adolescent Health Centers and Programs (CAHCPs) outreach activities 1, 2 and 5 as outlined in MSA 04-13.

7. If non-clinical adolescent health center programming occurs on school property, there shall be a current interagency agreement defining roles and responsibilities between the contracting agency and the local school district.

8. The non-clinical health center shall have secured storage for supplies and equipment, and security of paper and electronic records if individual health information is collected.

9. The non-clinical health center shall establish a quality assurance mechanism (e.g. client satisfaction survey, focus group, other methodologies) that evaluates the effectiveness and appropriateness of services to teens.

MINIMUM PROGRAM REQUIREMENTS FOR ELEMENTARY SCHOOL BASED HEALTH CENTERS

ELEMENT DEFINITION:

Services designed specifically for elementary school-aged children 5-10 years of age aimed at achieving the best possible physical, intellectual, and emotional status. Included in this element are Elementary School Based Health Centers designed to provide primary care, psychosocial and health promotion/disease prevention, and outreach services.

MINIMUM PROGRAM REQUIREMENTS FOR ELEMENTARY SCHOOL BASED HEALTH CENTERS:

Services

1. The elementary health center shall provide a range of services based on a needs assessment of the community/target population and approved by the advisory committee. At a minimum the services shall include immunization screening and administration with the utilization of the Michigan Childhood Immunization Registry, primary care including health maintenance (well child/EPSDT) and care for acute illness and chronic conditions, laboratory tests for pregnancy, communicable diseases and primary prevention, mental health counseling, access or referral to dental services, referral for other needed clinical services not available at the elementary health center, health education including communicable disease education, and shall follow preventive services guidelines (such as American Academy of Pediatrics, Bright Futures, etc.).

2. The elementary health center shall not, as part of the services offered, provide abortion counseling, services, or make referrals for abortion services.

3. The clinical services provided shall meet the recognized, current standards of practice for care and treatment of elementary school-aged children (ages 5-10).

4. The elementary health center, if on school property, shall not prescribe, dispense, or otherwise distribute family planning drugs and/or devices.

5. The elementary health center shall provide Medicaid outreach services to eligible children and families and shall adhere to Child and Adolescent Health Centers and Programs (CAHCPs) outreach activities as outlined in MSA 04-13

Administrative

6. Written approval by the school administration and local school board exists for the following:

    a) location of the elementary health center on school property or in a building

where K-6 education (or other grade variation) is provided;
b) administration of a needs assessment process to determine priority health services;
c) parental consent policy;
d) services rendered in the health center;
e) policy and procedure on how children will access the center during school hours.

7. The elementary health center shall have a current interagency agreement defining roles and responsibilities between the contracting agency and the local school district.

8. The elementary health center shall be accessible to all students enrolled in the school building.

9. The elementary health center shall be open during hours accessible to its target population, and provisions must be in place for the same services to be delivered during times when school is not in session. Not in session refers to times of the year when schools are closed for extended periods, such as holiday, spring breaks, and summer vacation. These provisions shall be posted, given to and/or explained to clients, and presented in writing to parents or guardians and school staff including an answering service/machine message. The center shall provide clinical services a minimum of five days a week. Total provider clinical time shall be at least 30 hours per week. Hours of operation must be posted in areas frequented by the target population and communicated to parents/guardians and school staff. The center shall have a written plan for after-hours and weekend care, which shall either be posted, given to, and/or explained to clients and communicated to parents/guardians and school staff.

10. The elementary health center shall have a licensed physician as a medical director who supervises the medical services provided. Written standing orders and clinical procedures approved by the medical director and the contracting agency shall be available for use by clinical staff.

11. The elementary health center shall be staffed by a certified nurse practitioner (Pediatric Nurse Practitioner (PNP), Family Nurse Practitioner (FNP), or School Nurse Practitioner (SNP), licensed physician, or a licensed physicians assistant with pediatrics experience working under the supervision of a physician during all hours of clinic operation. The nurse practitioner must be certified or eligible for certification in Michigan and accredited by an appropriate national certification association or board. The physician and physician assistant must be licensed to practice in Michigan.

12. The elementary health center must be staffed with a minimum of a .5 FTE licensed counselor and/or certified Social Worker.

13. The elementary health center shall implement a quality assurance plan. Components of the plan shall include at a minimum:
    a) ongoing clinical and medical records reviews by peers to determine that conformity exists with current standards of practice. A system shall also be in place to implement corrective actions when deficiencies are noted.

b) completing, updating, or having access to a comprehensive needs assessment done within the last two to three years to determine the health needs of the target population.
c) conducting an age-appropriate client satisfaction survey/assessment periodically, and/or satisfaction surveys with parents and/or school staff, but no less than once per year.

14. A local advisory committee shall be established and operated as follows:
    a) A minimum of two meetings per year.
    b) The committee must be representative of the community and must be comprised of at least 50% members of the community.
    c) Health care providers shall not represent more than 50% of the committee.
    d) Parents must be represented on the committee with at least 1/3 of the committee comprised of parents of school-aged children.
    e) School staff must be represented on the committee, including at least one of the following: school nurses (if applicable), administrative positions, teachers, specialty school program staff, and/or student support team members.
    f) The committee should recommend the implementation and types of services rendered by the health center.
    g) The advisory committee must approve the following policies and the elementary school based health center must develop applicable procedures:

        1. Parental consent;
        2. Requests for medical records and release of information that include the role of the noncustodial parent and parents with joint custody;
        3. Confidential services; and
        4. Disclosure by clients or evidence of child physical or sexual abuse, and/or neglect

15. The elementary health center shall have space and equipment adequate for private physical examinations, private counseling, reception, laboratory services, secured storage for supplies and equipment, and secure paper and electronic client records. The physical facility must be barrier-free, clean, and safe.

16. The elementary health center staff shall follow all Occupational Safety and Health Act guidelines regarding transmission of blood borne pathogens, such as HIV and Hepatitis B, to health care and Public Safety Workers.

17. The elementary health center shall conform to the regulations determined by the Department of Health and Human Services for laboratory standards.

<u>Billing and Fee Collection</u>

18. The elementary health center shall establish and implement a sliding fee scale, which is not a barrier to health care for children. No child can be denied services because of inability to pay.

19. The elementary health center shall establish and implement a process for billing Medicaid, Qualified Health Plans and other third party payers.

20. The elementary health center shall establish and implement a process for working with assigned Primary Care Providers (PCP), which includes at a minimum a process for informing the PCP when a child is seen at the health center and the level of service that occurred.

Attachment D

APPLICATION CHECKLIST AND FAX BACK FORM FOR PLANNING GRANT APPLICANTS:

Sponsoring Agency: _____

Clinic Name: _____

Contact Name: _____ **Fax**: _____

- ❑ Is the Fax-Back Form: Confirmation of Receipt completed?
- ❑ Is the Application Cover Page signed by the authorized signatory?
- ❑ Is the Service Area and Target Population Demographic Worksheet completed?
- ❑ Does the cover letter include the appropriate assurances regarding family planning devices and abortion counseling/services/referral?
- ❑ Is the narrative double-spaced and typed in a font no smaller than Times 12 point?
- ❑ Is the narrative complete (i.e. responds to numbers 1-7 of the planning guidance and the financial plan section)?
- ❑ Does the workplan follow the required format?
- ❑ Are all budget pages complete and accurate?
- ❑ Is the Need Statement Worksheet complete and accurate?
- ❑ Is a map of the proposed service area included?
- ❑ Is the initial roster of Community Advisory Council members included?
- ❑ Have you included Letters of Commitment from the local health department and the superintendent's office or building principal ***and*** at least three additional Letters of Commitment to participate from local partners interested in participating on the Community Advisory Council?
- ❑ Have you included at least three Letters of Need from suggested local agencies? Is a Letter of Need from the local Community Collaborative included?
  (*If these letters also contain statements supporting the planning process and indicate a commitment to participate in the process, they will contribute to the requirements under Letters of Commitment as well.)*
- ❑ Have you included 1 original and 4 complete copies of the application?

ASSEMBLE THE ORIGINAL PLANNING GRANT AND FOUR COPIES IN THE FOLLOWING ORDER:

Fax-Back Form: Confirmation of Receipt with all information COMPLETE
Part A -Application Cover Sheet with original signatures
-Service Area and Target Population Demographics Worksheet
Part B –Cover Letter and Assurances and Certifications with original signatures
Part C – Grant Program Details

- Title Page
- Table of Contents
- Narrative description of all requested information
- Workplan in required format
- Financial Plan

Part D -- Budget, Budget Summary, Budget Detail and other required budget information
Attachments

- Need Statement Worksheet
- Map of proposed service area
- Initial roster of Community Advisory Council members
- Letters of Commitment
- Letters of Need

APPLICATION CHECKLIST AND FAX BACK FORM FOR EXISTING CENTERS:

Sponsoring Agency: _____

Clinic Name: _____

Contact Name: _____ **Fax**: _____

- ❑ Is the Fax-Back Form: Confirmation of Receipt completed?
- ❑ Is the Application Cover Page completed ***and*** signed by the authorized signatory?
- ❑ Does the cover letter include the appropriate assurances regarding family planning devices and abortion counseling/services/referral ***and*** contain original signatures?
- ❑ Is the narrative double-spaced and typed in a font no smaller than Times 12 point?
- ❑ Is the narrative complete (i.e. responds to numbers 2-8 of the existing centers guidance and financial plan section)?
- ❑ Does the workplan follow the required format?
- ❑ Are all budget pages complete and accurate?
- ❑ Is the Budget Summary signed by the authorized signatory?
- ❑ Is a map of the proposed service area included?
- ❑ Have you included at least three Letters of Need from suggested local agencies, one of which must be from the local multi-purpose collaborative body? (*If these letters also contain statements of support, they will contribute to the requirements under #5. Community Collaboration/Support-Letters of Endorsement as well.)*
- ❑ Have you included at least five Letters of Endorsement, one of which must be from the local health department?
- ❑ Have you included a membership list of the existing or potential Advisory Committee?
- ❑ If available, have you included policies and procedures approved by the Advisory Committee for: parental consent, request for medical records and release of information, confidential services (clinical only) and disclosure of child physical or sexual abuse or neglect?
- ❑ Have you included an organizational chart?
- ❑ If the center is located on school property, have you included a copy of the interagency agreement between the sponsoring agency and the local school district which defines the roles and responsibilities of each party?
- ❑ If the center is located on school property, have you included written approval by the school administration for: location of the health center, administration of a health survey to students enrolled in the school, parental consent policy and services rendered in the health center program?
- ❑ Have you included 1 original and 4 complete copies of the application?

ASSEMBLE THE ORIGINAL AND FOUR COPIES IN THE FOLLOWING ORDER:

Fax-Back Form: Confirmation of Receipt with all information COMPLETE
Part A -Application Cover Sheet with original signatures
Part B –Cover Letter and Assurances and Certifications with original signatures
Part C – Grant Program Details

- Table of Contents
- Project Abstract
- Narrative description of all requested information
- Workplan in required format
- Financial Plan

Part D -- Budget, Budget Summary, Budget Detail and other required information
Attachments

- Map of proposed service area
- Letters of Need
- Letters of Endorsement
- Proposed or Existing Advisory Group Members
- Policies and Procedures (if available)
- Interagency Agreement with School (if providing services on school property)

Attachment E:

REPORT FACTSHEET FOR PLANNING GRANTEES:

WHEN ARE REPORTS DUE?

Required Report	Due Date
Final Budget Detail (covers the period of April 1, 2005 - September 30, 2005)	November 30, 2005
Narrative Progress Reports (includes narrative of progress on objectives and activities as outlined in the proposal, identification of barriers, and identification of any technical assistance needs)	*Progress Reports are due:* June 1, 2005 , August 1, 2005
Final Summary Report including FY05-06 Plan of Operation (includes narrative of progress on objectives and activities as outlined in the proposal for the period of April 1, 2005 – August 30, 2005; must also include a detailed plan of operation and implementation timeline for start-up of the proposed SB/SL-CAHC as well as identification of barriers and any technical assistance needs for implementation)	September 1, 2005

WHEN IS THE FINAL EXPENDITURE REPORT DUE?

There is one financial expenditure report that is required for Planning Grantees. This report should be submitted on the following schedule (*for tracking of expenditures, not invoice for payment*):

Required Report	Due Date
Financial Status Report: DCH-0384(E) (includes expenditures for the period of April 1, 2005 through September 30, 2005)	November 30, 2005

All reports should be submitted to*:

Carrie Tarry, Adolescent Health Coordinator
Michigan Department of Community Health
Division of Family and Community Health
PO Box 30195
Lansing MI 48909

Please also send an original copy of the Financial Status Report and the Final Budget Detail to:

Pat Burke, Chief Financial Officer
Michigan Primary Care Association
2525 Jolly Road, Ste. 280
Okemos, MI 48864

***Each planning grant will be assigned a Community Consultant. Progress reports should also be sent to your assigned Community Consultant.**

REPORT FACTSHEET FOR STATE-FUNDED ADOLESCENT HEALTH CENTERS:

WHEN ARE DATA REPORTS DUE?
There are four *data* reports that are required for State-Funded Adolescent Health Centers. These reports should cover the following time frames:

Data Reports	Due Date
CY 2004 Year-End Data Report: Centers funded in FY05 must submit a calendar year-end data report covering the period of January 1 B December 31, 2005.	January 30, 2006
1st Quarter Report (including YTD): January 1 B March 31, 2006	April 15, 2006
2nd Quarter Report (including YTD): April 1 B June 30, 2006	July 15, 2006
3rd Quarter Report (including YTD): July 1 B September 30, 2006	October 15, 2006

WHEN ARE BILLING REPORTS DUE?

All state-funded teen health centers must be billing. Billing reports following the appropriate format should be submitted along with quarterly data reports. The billing data reports will be compiled at the end of the CY, like the data reports and will be submitted to the Legislature in April of 2007.

WHEN ARE FINANCIAL STATUS REPORTS DUE?
There are two financial status reports that are required for State-funded Teen Health Centers. These reports should be submitted on the following schedule (*for tracking of expenditures, not invoice for payment*):

Required Report	Due Date
Quarterly Financial Status Reports (includes expenditures for the previous quarter)	October 1 – December 31 – DUE January 30 January 1 – March 31 – DUE April 15 April 1 – June 3 – DUE July 15
Final Financial Status Report (includes expenditures for the period of October 1, 2004 B September 30, 2006)	November 30, 2006

Other reports your program is required to submit annually include:

Required Report	**Due Date**
Final Budget Detail (Covers the period of October 1, 2005 - September 30, 2006)	November 30, 2006
Annual Summary Report (includes narrative of progress on objectives and activities proposed in the FY05 work plan and outreach plan and should cover the period of October 1, 2005 -- September 30, 2006)	November 30, 2006
Adolescent Health Education Presentation Form Centers must submit this form for the period of January 1 B December 31, 2005.	January 30, 2006

WHO SHOULD WE SUBMIT REPORTS TO?

All reports listed above should be submitted to:

Carrie Tarry, Adolescent Health Coordinator
Division of Family and Community Health
Michigan Department of Community Health
PO Box 30195
Lansing MI 48909

Please send an original copy of the quarterly FSRs and the Final Budget Detail to:

Pat Burke, Chief Financial Officer
Michigan Primary Care Association
2525 Jolly Road, Ste. 280
Okemos, MI 48864

FY06 REPORT FACTSHEET FOR STATE-FUNDED NON-CLINICAL ADOLESCENT HEALTH CENTERS:

WHEN ARE REPORTS DUE?

The following reports are due annually:

Required Report	Due Date
Adolescent Health Education Presentation Form Non-clinical centers must submit this form quarterly with the quarterly narrative reports. **A year-end report for the period of January 1, 2005 – December 31, 2006 is due January 30, 2006.**	CY2005 Year-end Report – Due January 30, 2006 January 1 – March 31, 2006 – DUE April 15, 2006 April 1 – June 30, 2006 – DUE July 15, 2006 July 1 – September 30, 2006 – DUE October 15, 2006
Adolescent Health Year End Report of Services & Referrals Non-clinical centers must submit this form quarterly with the narrative reports and Health Education & Presentation Form.	CY2005 Year-end Report – Due January 30, 2006 January 1 – March 31, 2006 – DUE April 15, 2006 April 1 – June 30, 2006 – DUE July 15, 2006 July 1 – September 30, 2006 – DUE October 15, 2006
Final Budget Detail (covers the period of October 1, 2005-September 30, 2006)	November 30, 2006
Quarterly Summary Reports (includes narrative of progress on objectives and activities proposed in MDE continuation application, identification of barriers, and identification of any technical assistance needs relative to program delivery and administration)	Quarterly reports are due to MDCH for the following time periods: October 1 – December 31, 2005 – DUE Jan. 30, 2006 January 1 – March 31, 2006 – DUE April 15, 2006 April 1 – June 30, 2006 – DUE July 15, 2006 *The fourth quarter report will be waived in lieu of the annual summary report.
Annual Summary Report (includes narrative of progress on objectives and activities proposed in MDE continuation application and should cover the period of October 1, 2005-September 30, 2006)	November 30, 2006

WHEN ARE FINANCIAL STATUS REPORTS DUE?
There are two financial status reports that are required for state-funded non-clinical teen health centers. These reports should be submitted on the following schedule (*for tracking of expenditures, not invoice for payment*):

Required Report	**Due Date**
Quarterly Financial Status Reports (includes expenditures for the previous quarter)	October 1 – December 31 – DUE January 30 January 1 – March 31 – DUE April 15 April 1 – June 3 – DUE July 15
Final Financial Status Report (includes expenditures for the period of October 1, 2004 B September 30, 2006)	November 30, 2006

WHO SHOULD WE SUBMIT REPORTS TO?

All reports should be submitted to:

Carrie Tarry, Adolescent Health Coordinator
Michigan Department of Community Health
Division of Family and Community Health
PO Box 30195
Lansing MI 48909

Please also send an original copy of the quarterly FSRs, and the Final Budget Detail to:

Pat Burke, Chief Financial Officer
Michigan Primary Care Association
2525 Jolly Road, Ste. 280
Okemos, MI 48864

Attachment F

Service Area and Target Population Demographics Worksheet

Service Area/Target Population to which demographic data applies *(Use the Service Area/Target Population described on page 1 of the application.):*

_____

	Demographic Characteristics	Service Area / Target Population Data	
		#	%
RACE / ETHNICITY	White (non-Hispanic)		
	Black or African-American (non-Hispanic)		
	Hispanic/Latino		
	American Indian or Alaskan Native		
	Asian/Pacific Islander		
	Other		
	Total Population		
INCOME AS A PERCENT OF POVERTY LEVEL	Below 100 Percent		
	100 to 199 Percent		
	200 Percent and Above		
	Unknown		
PRIMARY THIRD PARTY PAYMENT SOURCE	Medicaid		
	Other Public Insurance (e.g. MI Child)		
	Private Insurance		
	None/Uninsured		
SPECIAL POPULATIONS / OTHER DATA	Population Ages 5-9		
	Population Ages 10 – 14		
	Population Ages 15 – 21		
	Free and Reduce Priced School Lunches		
	Migrant/Agricultural Worker		
	Public Housing Residents		

Provide year and source of data in proposal narrative as directed in narrative instructions.

Attachment G

Need Statement Worksheet

As part of the planning proposal, applicants MUST COMPLETE AND SUBMIT this two-page Need Statement Worksheet. The scoring of the Preliminary Assessment of Needs/Assets of Your Communities children and/or youth section of the proposal will be based on data about the proposed service area/target population as presented in both the narrative and on this worksheet. If service area/target population data are not available for any of the following, the applicant may provide broader data (i.e. county level data) and must indicate the broader area to which the data applies.

The following guidelines are in place for completing the Need Statement Worksheet:

1. All responses must be given in the format requested (i.e., if a percentage is requested, the response must be a percentage; if a rate is requested, the response must be a rate).
2. Use the most geographically focused data available.
3. No more than one response should be submitted for each question.
4. **All responses indicated below should be clearly referenced and explained in the proposal narrative under the Preliminary Assessment of Need/Assets of Youth section.**
5. **Documentation of the year and source of the data in the narrative is required.**
6. Applicants are expected to provide the most recently available data.

1. BARRIERS AND ACCESS TO CARE: Each applicant must respond to **FOUR** of the following in this section:

(a) **Geographic barriers** based on average travel time/distance by the means most commonly used by the target population (e.g., car, public transportation, walking, etc.) from school to the nearest source of primary care that is accessible to the target population (e.g., a physician willing to accept new Medicaid patients and/or has a published sliding fee schedule for people below 200 percent of poverty).

Check ONE of the following:

- ❑ 0 – 20 minutes
- ❑ 21 – 29 minutes
- ❑ 30 – 44 minutes
- ❑ 45 – 59 minutes
- ❑ 60 – 74 minutes
- ❑ 75 + minutes

OR

- ❑ 0 – 10 miles
- ❑ 11 – 19 miles
- ❑ 20 – 29 miles
- ❑ 30 – 49 miles
- ❑ 50 – 59 miles
- ❑ 60 + miles

(b) **Shortage of primary care physicians** necessary to meet the needs of the target population = Designation of the service area as a Federal Health Professional Shortage Area (HPSA):

- ❑ NO
- ❑ YES

(c) **Percentage of Children Ages 5 to 17 Living in Poverty** in the service area:

- ❑ 0 - 5%
- ❑ 6 - 10%
- ❑ 11 - 15%
- ❑ 16 - 20%
- ❑ 21 - 25%
- ❑ 26+ %

(d) **Percentage of Uninsured Individuals** in the service area [If information is unavailable, use number of individuals below 200 percent of poverty minus the number of Medicaid beneficiaries]:

- ❑ 0 - 5%
- ❑ 6 - 10%
- ❑ 11 - 15%
- ❑ 16 - 20%
- ❑ 21 - 25%
- ❑ 26+ %

(e) **Percentage of Children Age 0 to 18 years in the service area who are insured by Medicaid**:

- ❑ 0 - 9%
- ❑ 10 - 14%
- ❑ 15 - 24%
- ❑ 25 - 34%
- ❑ 35+ %

2. HEALTH DISPARITY FACTORS: Each applicant must respond to **ten** (**10**) of the following items in the proposal narrative under the Preliminary Assessment of Need/Assets of Youth section.

Responses must be based on the rate/percentage/etc. requested below and should be based on child and adolescent populations, where available and applicable, in the proposed service area/target population. **Please check all of the health disparity factors addressed in the Preliminary Assessment of Need narrative.**

Maternal and Child Health Indicators:

- ❑ Immunization rate
- ❑ Lead poisoning (percent of children tested and percent tested diagnosed as "lead poisoned")
- ❑ Low birth weight rate (per 1,000 live births)
- ❑ Infant mortality rate (per 1,000 live births)
- ❑ Late entry into prenatal care
- ❑ Teen pregnancy rate (per 1,000 female teens) ages 10 to 14 and/or 15 to 19
- ❑ Teen birth rate (per 1,000 female teens) ages 10 to 14 and/or 15 to 19

Chronic and Other Disease and Health Risks:

- ❑ Asthma level (rate or percentage) in youth
- ❑ Asthma hospitalization (rate per 10,000 population ages 1 to 14; other age ranges acceptable if available)
- ❑ Diabetes rate
- ❑ Dental disease rate (e.g., caries, lack of teeth, periodontal disease)
- ❑ Obesity rate
- ❑ Suicide rate
- ❑ HIV/AIDS and STI rates
- ❑ Unintentional injury rate
- ❑ Depression rate
- ❑ Rate of serious mental illness (e.g., schizophrenia, bi-polar, etc.)
- ❑ Substance abuse rate (Identify for which substance/s data is referencing)

Other:

- ❑ Rate of school absenteeism
- ❑ Rate or percentage of school suspension
- ❑ Rate or percentage of school dropout
- ❑ Data from student surveys conducted within last two years: (e.g., health risk behavior or assets surveys): *ONE RESPONSE ONLY*
- ❑ Unemployment rate in the service area
- ❑ Percentage age 5 years or older who speak a language other than English at home
- ❑ Other (must be health related): *ONE RESPONSE ONLY*

Attachment H

Required Work Plan Format for Planning Grants and Existing Centers

Program Goal: *Specify Mandatory/Other Area* Goal should be time-framed and measurable.			
Objectives: Objectives should be time-framed, measurable, and relate to accomplishing the stated goal.			
Services/Activities	**Person Responsible**	**Timeframe**	**Evaluation**
Describe services and activities in enough detail so that it is clear WHAT the activity entails including number of participants, name of intervention/curriculum (if applicable), frequency and duration of service/activity and any other supporting information that will provide reviewers with a clear picture of the day-to-day service/activity that will be provided. It is helpful to point out if the activities are integrated or linked to other services/activities in your plan. Your services and activities should be clearly linked to one or more of the stated objectives. One service/activity may relate to accomplishing more than one objective.	Clearly identify the person(s) responsible for carrying out each service/activity described. Please provide titles/positions, not names of individuals.	Provide a time frame for implementing each service/ activity described	Describe evaluation methods and measures. The evaluation plan should include a measurement of accomplishing the goal and each objective.

MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Distribution: Medicaid Health Plans 04-08
Local Health Departments 04-05
Federally Qualified Health Centers 04-01

Issued: August 24, 2004

Subject: Outreach Activities

Effective: October 1, 2004

Programs Affected: Medicaid

Child & Adolescent Health Centers and Programs (CAHCPs), under agreement with the Michigan Department of Community Health, will begin performing Medicaid outreach activities on behalf of the Medicaid Health Plans (MHPs) effective October 1, 2004. CAHCPs were formerly known as school-based, school-linked health centers and the Michigan Model program. This bulletin describes the categories of outreach services that the CAHCPs are expected to perform under the agreement. All outreach activities must be specific to the Medicaid program.

CAHCPs are expected to perform outreach activities to potential and current Medicaid beneficiaries in the following categories:

Medicaid Outreach and Public Awareness
Activities that are to be performed include those associated with informing eligible or potentially eligible individuals about Medicaid covered benefits and how to access them. This includes providing information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services or making referral for such services. This category of outreach also includes coordinating and presenting information about Medicaid through media resources, health fairs and other community forums.

Facilitating Medicaid Eligibility Determination
Activities in this category of Medicaid outreach are related to assisting potential Medicaid eligible individuals in applying for Medicaid benefits. This includes explaining eligibility rules and assisting with the completion of the Medicaid application. It also includes referring individuals to the Michigan Family Independence Agency to make application for benefits.

Program Planning, Policy Development and Interagency Coordination Related to Medical Services
Under this category of outreach activities, the CAHCPs must work collaboratively with other community agencies to assure the delivery of Medicaid-covered services. This includes tracking requests for referrals and coordinating services with the Medicaid Health Plans. Activities that include development of health programs and services targeted to the Medicaid population fall into this category.

Referral, Coordination, and Monitoring of Medicaid Services
Outreach activities in this category include development of program resources for program-specific services at CAHCPs. Coordination of programs and services at the school and/or community levels and monitoring delivery of Medicaid services within the school and/or community are included. CAHCPs may provide information such as that for EPSDT services or making referrals for family planning services.

Medicaid-Specific Training on Outreach Eligibility and Services
Activities that fall into this category of outreach are those that focus on coordinating, conducting, or participating in training and seminars to instruct patients, school personnel, health center staff and community members about the Medicaid program and benefits and how to assist families in accessing Medicaid services. Outreach-related activities include training that enhances early identification, screening and referral of children and adolescents for EPSDT services or behavioral health needs. This category includes development and presentation of training modules regarding Medicaid eligibility and benefits to health center and school health staff and other stakeholders, such as parents and guardians.

Related Documents

The Department will work with the MHPs and the Michigan Primary Care Association (representing the CAHCPs) to develop agreements through which these outreach activities will be coordinated.

Public Comment

Public comment on this bulletin will be accepted and considered for future policy revisions. Comments may be submitted to MDCH Program Policy Division, PO Box 30479, Lansing, MI 48909-7979.

Manual Maintenance

Retain this bulletin for future reference.

Questions

Any questions regarding this bulletin should be directed to Provider Support, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approval

Paul Reinhart, Director
Medical Services Administration

INSTRUCTIONS FOR PREPARATION OF BUDGET FORMS (DCH-0385, DCH-0386)

I. INTRODUCTION

The budget should reflect all expenditures and funds associated with the program, including local, state and federal funding sources. When developing a budget it is important to note that total expenditures for a program should equal total funds.

The Program Budget Summary (DCH-0385) is utilized to provide a standard format for the presentation of the financial requirements (both expenditure and funding) for each applicable program. Detail information supporting the Program Budget Summary is contained in the Program Budget-Cost Detail Schedule (DCH-0386). General instruction for the completion of these forms follows in Sections II-III.

II. PROGRAM BUDGET SUMMARY (DCH-0385) FORM PREPARATION

Use the **Program Budget Summary (DCH-0385)** supplied by the Michigan Department of Community Health. An example of this form is attached **(see Attachment B.1)** for reference. **The DCH-0386 form should be completed prior to completing the DCH-0385 form.** (Please note: the excel workbook version of the DCH 0385-0386 automatically updates the Program Summary amounts as the user completes the DCH-0386).

A. Program - Enter the title of the program.

B. Date Prepared - Enter the date prepared.

C. Page ___ of ___ - Enter the page number of this and the total number of pages comprising the complete budget package.

D. Contractor - Enter the name of the Contractor.

E. Budget Period - Enter the inclusive dates of the budget period.

F. Address - Enter the complete address of the Contractor.

G. Original or Amended - Check whether this is an original budget or an amended budget. The budget attached to the agreement at the time it is signed is considered the original budget although it may have been revised in the negotiation process. If the budget pertains to an amendment, enter the amendment number to which the budget is attached.

H. Federal Identification Number - Enter the Federal Identification Number as stated on page one of Part I of the agreement.

I. Expenditure Category Column – All expenditure amounts for the DCH-0385 form should be obtained from the total amounts computed on the Program Budget - Cost Detail Schedule (DCH-0386).

Expenditures:

1. Salaries and Wages
2. Fringe Benefits
3. Travel

PROGRAM BUDGET SUMMARY (DCH-0385) FORM PREPARATION (continued)

4. Supplies and Materials
5. Contractual (Subcontracts)
6. Equipment
7. Other Expenses
8. Total Direct
9. Indirect Cost
10. Total Expenditures

Source of Funds:

11. Fees and Collections - Enter the total fees and collections estimated. The total fees and collections represent funds that the program earns through its operation and retains for operation purposes. This includes fees for services, payments by third parties (insurance, patient collections, Medicaid, etc.) and any other collections.
12. State Agreement - Enter the amount of MDCH funding allocated for support of this program. (This amount should equal the amount reported in box 16 of the DCH 0016.) State percentages are not required.
13. Local - Enter the amount of local contractor funds utilized for support of this program. Local percentages are not required. In-kind and donated services from other agencies/sources should not be included on this line.
14. Federal - Enter the amount of any Federal grants received directly by the Contractor in support of this program and identify the type of grant received in the space provided.
15. Other - Enter and identify the amount of any other funding received. Other funding could consist of foundation grants, United Way grants, private donations, fund-raising, charitable contributions, etc. In-kind and donated services should not be included unless specifically requested by MDCH.
16. Total Funding - The total funding amount is entered on line 16. This amount is determined by adding lines 12 through 15. The total funding amount must be equal to line 10 - Total Expenditures.

J. Total Budget Column - The Program Budget Summary is designed for use in presenting a budget for a specific program agreement funded in part by or throu the Department or some other non-local funding source. Total Budget column represents the program budget amount. **The "J" Total Budget column must be completed while the remaining columns are not required unless additional detail is required by the Department.**

III. PROGRAM BUDGET-COST DETAIL SCHEDULE (DCH-0386) FORM PREPARATION

Use the **Program Budget-Cost Detail Schedule (DCH-0386)** supplied by the Michigan Department of Community Health. An example of this form is attached **(see Attachment B.2)** for reference.

A. Page ____ of ____ - Enter the page number of this page and the total number of pages comprising the complete budget package.

B. Program - Enter the title of the program.

C. Budget Period - Enter the inclusive dates of the budget period.

D. Date Prepared - Enter the date prepared.

E. Contractor - Enter the name of the contractor.

F. Original or Amended - Check whether this is an original budget or an amended budget. If an amended budget, enter the amendment number to which the budget is attached.

G. Salaries and Wages - Position Description - List all position titles or job descriptions required to staff the program. This category includes compensation paid to all permanent and part-time employees on the payroll of the contractor and assigned directly to the program. This category does not include contractual services, professional fees or personnel hired on a private contract basis. Consulting services, professional fees or personnel hired on a private contracting basis should be included in Other Expenses. Contracts with sub-recipient organizations such as cooperating service delivery institutions or delegate agencies should be included in Contractual (Subcontract) Expenses.

H. Positions Required - Enter the number of positions required for the program corresponding to the specific position title or description. This entry may be expressed as a decimal when necessary. If other than a full-time position is budgeted, it is necessary to have a basis in terms of a time study or time reports to support time charged to the program.

I. Total Salary - Compute and enter the total salary cost by multiplying the number of positions required by the annual salary.

J. Comments - Enter any explanatory information that is necessary for the position description. Include an explanation of the computation of Total Salary in those instances when the computation is not straightforward (i.e., if the employee is limited term and/or does not receive fringe benefits).

PROGRAM BUDGET-COST DETAIL SCHEDULE (DCH-0386) FORM PREPARATION
(continued)

K. Salaries and Wages Total - Enter a total in the Position Required column and the Total Salaries and Wages column. The total salary and wages amount is transferred to the Program Budget Summary - Salaries and Wages expenditure category. If more than one page is required, a subtotal should be entered on the last line of each page. On the last page, enter the total Salaries and Wages amounts.

L. Fringe Benefits - Specify applicable (**"X"**) for staff working in this program. Enter composite fringe benefit rate and total amount of fringe benefit. (The composite rate is calculated by dividing the fringe benefit amount by the salaries and wage amount.) This category includes the employer=s contributions for insurance, retirement, FICA, and other similar benefits for all permanent and part-time employees assigned to the program.

M. Travel - Enter cost of employee travel (mileage, lodging, registration fees). **Use only for travel costs of permanent and part-time employees assigned to the program**. This includes cost for mileage, per diem, lodging, registration fees and approved seminars or conferences and other approved travel costs incurred by the employees (as listed under the Salaries and Wages category) for conducting the program. **Specific detail should be stated in the space provided on the Cost Detail Schedule (DCH-0386) if the Travel line (line 3) exceeds 10% of the Total Expenditures (line 10).** Travel of consultants is reported under Other Expenses - Consultant Services.

N. Supplies & Materials - Enter cost of supplies & materials. This category is used for all consumable and short-term items and equipment items costing less than five thousand dollars ($5,000). This includes office supplies, computers, printers, printing, janitorial, postage, educational supplies, medical supplies, contraceptives and vaccines, tape and gauze, education films, etc., according to the requirements of each applicable program. **Specific detail should be stated in the space provided on the Cost Detail Schedule (DCH-0386) if the Supplies and Materials line (line 4) exceeds 10% of the Total Expenditures (line 10).**

O. Subcontracts – **Specify the subcontractor(s) working on this program in the space provided under line 5.** Specific details must include: 1) subcontractor(s) name and address, 2) amount by subcontractor and 3) the total amount for all subcontractor(s). Multiple small subcontracts can be grouped (e.g., various worksite subcontracts). Use this category for written contracts or agreements with sub-recipient organizations such as affiliates, cooperating institutions or delegate contractors when compliance with federal grant requirements is delegated (passed-through) to the sub-recipient contractor. Vendor payments such as stipends and allowances for trainees, fee-for-service or fixed-unit rate patient care, consulting fees, etc., are to be identified in the Other Expense category.

P. Equipment - Enter a description of the equipment being purchased (including number of units and the unit value), the total by type of equipment and total of all equipment. This category includes stationary and movable equipment to be used in carrying out the objectives of the program. The cost of a single unit or piece of equipment includes the necessary accessories, installation costs and any taxes. Equipment is defined to be an article of non-expendable tangible personal property having a useful life of more than one (1) year and an acquisition cost of $5,000 or more per unit. **Equipment items costing less than five thousand dollars ($5,000) each are to be included in the Supplies and Materials category. All equipment items summarized on this line must include: item description, quantity and budgeted amount and should be individually identified in the space provided under line 6. Upon completing equipment purchase, equipment must be tagged and listed on the Equipment Inventory Schedule (see Attachment B.3) and submitted to the agreement's contract manager.**

Q. Other Expenses - This category includes other allowable cost incurred for the benefit of the program. The most significant items should be specifically listed on the Cost Detail Schedule. Other minor items may be identified by general type of cost and summarized as a single line on the Cost Detail Schedule to arrive at a total Other Expenses category. Some of the more significant groups or subcategories of costs are described as follows and should be individually identified in the space provided on and under line 7. **Specific detail should be stated in the space provided on the Cost Detail Schedule (DCH-0386) if the Other Expenses line (line 7) exceeds 10% of the Total Expenditures (line 10).**

1. Communication Costs - Costs of telephone, telegraph, data lines, Internet access, etc., when related directly to the operation of the program.
2. Space Costs - Costs of building space, rental of equipment, instruments, etc., necessary for the operation of the program. If space is publicly owned, the cost may not exceed the rental of comparable space in privately owned facilities in the same general locality. Department funds may not be used to purchase a building or land.
3. Consultant Services - These are costs for consultation services, professional fees and personnel hired on a private contracting basis related to the planning and operations of the program, or for some special aspect of the project. Travel and other costs of these consultants are also to be included in this category.
4. Other - All other items purchased exclusively for the operation of the program and not previously included.

PROGRAM BUDGET-COST DETAIL SCHEDULE (DCH-0386) FORM PREPARATION
(continued)

Q. Total Direct Expenditures – Enter the sum of items 1 – 7 on line 8.

R. Indirect Cost Calculations - **Enter the allowable indirect costs for the budget.** Indirect costs can only be applied if an approved indirect cost rate has been established or an actual rate has been approved by a State of Michigan department (i.e., Michigan Department of Education) or the applicable federal cognizant agency and is accepted by the Department. Attach a current copy of the letter stating the applicable indirect cost rate. **Detail on how the indirect amount was calculated must be shown on the Cost Detail Schedule (DCH-0386)**.

S. Total Expenditures - Enter the sum of item 8 and 9 on line 10.

PROGRAM BUDGET SUMMARY

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

PROGRAM **(A)** Budget and Contracts			DATE PREPARED	Page **(C) 1** **2**
CONTRACTOR NAME **(D)** Michigan Agency			BUDGET PERIOD From: **(E)** 10/01/xx To: 9/30/xx	
MAILING ADDRESS (Number and Street) **(F)**			AGREEMENT: **(G)** ☐ **Original** ☒ **Amendment** ▶	Amendment Number **1**
CITY	STATE	ZIP Code	Federal ID Number **(H)**	

(I) EXPENDITURE CATEGORY				**(J) TOTAL BUDGET**
1. Salaries and Wages	**43,000**			**43,000**
2. Fringe Benefits	**11,180**			**11,180**
3. Travel	**5,000**			**5,000**
4. Supplies and Materials	**37,000**			**37,000**
5. Contractual (Subcontracts)	**3,500**			**3,500**
6. Equipment	**5,000**			**5,000**
7. Other Expenses:				
	8,000			**8,000**
8. **Total Direct Expenditures** (Sum of Lines 1-7)	**112,680**			**112,680**
9. Indirect Costs: Rate #1 %				
Indirect Costs: Rate #2 %				
10. **TOTAL EXPENDITURES**	**112,680**			**112,680**

SOURCE OF FUNDS:

11. Fees and Collections	**10,000**			**10,000**
12. State Agreement	**90,000**			**90,000**
13. Local	**12,680**			**12,680**
14. Federal				
15. Other(s):				
16. **TOTAL FUNDING**	**112,680**			**112,680**

AUTHORITY: P.A. 368 of 1978
COMPLETION: Is Voluntary, but is required as a condition of funding

The Department of Community Health is an equal opportunity employer, services and programs provider.

DCH-0385 (E) (Rev 4-04) (W) Previous Edition Obsolete. Also Replaces FIN-11

PROGRAM BUDGET – COST DETAIL

Use WHOLE DOLLARS ONLY MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

(B) PROGRAM Budget and Contracts	(C) BUDGET PERIOD FROM 10/01/xx TO 9/30/xx	(D) DATE PREPARED 7/01/xx
(E) CONTRACTOR Michigan Agency	**(F) ORIGINAL BUDGET**	**AMENDED BUDGET** AMENDMENT NUMBER 1

(G) 1. SALARIES & WAGES – POSITION DESCRIPTION	**(H) POSITIONS REQUIRED**	**(I) TOTAL SALARY**	**(J) COMMENTS**
Nurse	1	25,000	
Project Director	.5	18,000	
(K) Total Salaries and Wages	1.5	43,000	

(L) 2. FRINGE BENEFITS: (Specify)

☒ FICA ☐ LIFE INS. ☐ DENTAL INS ☒ COMPOSITE RATE

☒ UNEMPLOY INS. ☐ VISION INS. ☒ WORK COMP AMOUNT 26 %

☐ RETIREMENT ☐ HEARING INS.

☐ HOSPITAL INS. ☐ OTHER **TOTAL FRINGE BENEFITS** $ 11,180

(M) 3. TRAVEL (Specify if any item exceeds 10% of Total Expenditures)

Registered Nurse to attend 5 day seminar

TOTAL TRAVEL $ 5,000

(N) 4. SUPPLIES & MATERIALS (Specify if any item exceeds 10% of Total Expenditures)

Office Supplies 2,000

Medical supplies 35,000

TOTAL SUPPLIES & MATERIALS $ 37,000

(O) 5. CONTRACTUAL (Subcontracts)

Name	Address	Amount
ACME Evaluation Services	**555 Walnut, Lansing, MI 48933**	**$ 2,000**
Presentations Are Us	**333 Kalamazoo, Lansing, MI 48933**	**$ 1,500**

TOTAL CONTRACTUAL $ 3,500

(P) 6. EQUIPMENT (Specify)

Microscope $5,000

TOTAL EQUIPMENT $ 5,000

(Q) 7. OTHER EXPENSES (Specify if any item exceeds 10% of Total Expenditures)

Communication Costs $2,400

Space Costs $3,600

Consultant: John Doe, Evaluator, 100 Main, E. Lansing $2,000

TOTAL OTHER $ 8,000

(R) 8. TOTAL DIRECT EXPENDITURES (Sum of Totals 1-7) $112,680

(S) 9. INDIRECT COST CALCULATIONS

Rate #1: Base $ X Rate % Total $

Rate #2: Base $ X Rate % Total $

(T) 10. TOTAL EXPENDITURES (Sum of lines 8-9) $112,680

DCH-0386 FY2005 (E) (W) 4/04 COMPLETION IS A CONDITION OF FUNDING AUTHORITY: P.A. 368 OF 19

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
CONTRACT MANAGEMENT SECTION

EQUIPMENT INVENTORY SCHEDULE

Please list equipment items that were purchased during the grant agreement period as specified in the grant agreement budget, Attachment B.2. Provide as much information about each piece as possible, including quantity, item name, item specifications: *make, model,* etc. Equipment is defined to be a article of non-expendable tangible personal property having a useful life of more than one (1) year and an acquisition cost of $5,000 or more per unit. Please forward to this agreement's contract manager.

Contractor Name: _____ Contract #: _____ Date: _____

Quantity	Item Name	Item Specification	Tag Number	Budgeted Amount
1	**LW Scientific M5 Labscope**	• Binocular • Trinocular with C-mount or eye tube • 35mm and digital camera adapters available • Diopter adjustment • Inclined 30 degrees (45 degrees available), rotates 360 degrees • 10X/20 high point eyepieces	N0938438EW098	$ 5,000.00
				$
				$
				$
				$
				$
			Total	$ 5000.00

Contractor's Signature: _____ Date: _____

Attachment K

Budget Narrative Instructions

All proposals must include a budget narrative and a line-item budget for the project for the following timeframes:

- Planning grant proposals -- April 1 – September 30, 2005
- Existing CAHC proposals -- October 1, 2005 – September 30, 2006

Please note that for centers that do not currently receive funding from the State but who are awarded funding through this competitive process, an additional budget will be required after awards are announced for the period of April 1 – September 30, 2005. For this competitive process, all existing centers should submit budgets for the October 1, 2005-September 30, 2006 timeframe.

This attachment details information required in the budget narrative. In the budget narrative, applicants are expected to justify the total cost of the program and to list other sources of funding that contribute to the CAHC program.

Budget Justification. The budget justification must provide detailed descriptions of planned expenditures, including justification and rationale. All budget line items must be described in the budget narrative**.**

- *Salaries and Wages (personnel)* - For each staff position associated with the program provide their name, title, annual salary and percent of a full time equivalent (FTE) dedicated to the program. Describe the role of each staff person in achieving proposed program objectives. Salaries and wages for program supervision are allowable costs, proportionate to the time allocated to the proposed program.

- *Taxes and Fringe Benefits* - Indicate, by percentage of total salary, payroll and fringe rate (e.g. FICA, retirement, medical, etc.).

- *Travel* - Describe who is traveling and for what purpose. Include reimbursement rates for mileage, lodging and meals. Indicate how many miles, overnights, etc. will be supported annually. **Travel of consultants should not be included in this category but rather under the category of Other - Consultant Fees.** International travel cannot be supported with funding awarded under this RFP. Out of state travel must be reasonable and necessary to the achievement of proposed goals and objectives. Staff travel for training and skills enhancement should be included here and justified. *For planning grant proposals, please refer to pages 21 and 23 of this application guidance for required trainings both in Michigan and Nationally that must be reflected in the proposed budget.*

- *Supplies and Materials - Describe* the types and amount of supplies and materials that will be purchased. Include justification for level of support requested for items and how it relates to the proposed program. Items requested may include but are not limited to: postage, office supplies, screening devices, prevention materials, training supplies, postage, and audio/visual equipment (under $5,000).

- *Contractual* - Describe all subcontracts with other agencies. Include the purpose of the contract, method of selection and amount of the sub-contract. Contracts with *individuals* should be included in the *Other category as Consultant Fees*.

- *Equipment* - This category includes stationary and moveable equipment to be used in carrying-out the objectives of the program. Equipment items costing less than five thousand dollars ($5,000) each are to be included in the Supplies and Materials category.

- *Other Expenses* - This category includes all other allowable costs. Common expenditures in this category include the following, though your budget may include additional items.

    - ✓ *Consultant Services* - Provide the name (if known), hourly rate, scope of service and method of selection for each consultant to be supported. The expertise and credentials of consultants should be described. Provide rationale for use of consultant for specified services. Travel and other costs of these consultants are to be included in this category and justified.

    - ✓ *Space* - Include items such as rent and utilities in this category. Each of these costs must be described. The description must address the cost per month and indicate the method of calculating the cost. Cost for acquisition and/or construction of property are not allowable costs under this RFP.

    - ✓ *Communications* - Describe monthly costs associated with the following:
        - phone (average cost per month, proportionate to proposed program)
        - fax (average cost per month, proportionate to proposed program)
        - internet access/email service (average cost per month, proportionate to proposed program
        - teleconferencing (number of sessions, cost average cost per use)

    - ✓ *Printing and copying* - Describe costs associated with reproduction of educational and promotional materials (manuals, course hand-outs, pamphlets, posters, etc.). Do not include copying costs associated with routine office activities.

    - ✓ *Administrative Costs* - This category of cost is not allowed by the Department

    - ✓ *Indirect Costs* - Indirect costs are not allowed under this grant.

Other Funding Sources. If the applicant receives other funding to conduct services which are linked to the proposed program they are to supply the following information for each source.

- Source of funding
- Project period
- Annual amount of award
- Target population
- Brief description of intervention (2-3 sentences)

If applicant does not receive any other support for proposed service, indicate that this section is not applicable.